



PHOTO RELEASE FORM

I consent for all purposes of the reproduction and/or use of still photography in advertisement for Dr. Karen McCarthy.

In giving this consent, I release Dr. McCarthy from liability for any violation of any personal or proprietary right I may have in connection with such a sale, reproduction, or use.

Patient Name

SS Number

Phone

Address

Date

The signature provided below is that of the patient or if under 18 that of the legal parent or guardian of the minor above and have the legal authority to execute the above consent and release. I approve the foregoing and waiver any rights in the premises.

Signature / Date