Consent and Authorization for Release and Use of Photographs and Video Footage

by Ali Sepehr, MD

I, ___________________________________ , am a patient of Ali Sepehr, M.D., and have been or will be photographed during the course of my treatment. I hereby grant Dr. Ali Sepehr the on-going and unrestricted right to use my photographs for general information, web pages, education, scientific, medical and public relations purposes and to permit others to use them for these purposes.

I further acknowledge that I relinquish all right, title, and interest in these photographs, or any right to profit or gain directly or indirectly realized through the use of the photographs.

I further state that there have been no representations or inducements concerning this consent except as set forth herein.

I release and discharge Dr. Ali Sepehr and all parties acting under his license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

This consent may only be revoked in writing, signed by myself and delivered to Dr. Ali Sepehr. Such revocation shall thereafter be effective as to any further use not already committed to by Dr. Ali Sepehr. This consent is in consideration of consultations conducted and services performed and those to be conducted and performed by Dr. Ali Sepehr.

I hereby voluntarily and without compensation authorize pictures and/or video footage to be made of me. I have read and understand the foregoing and I consent to the use of my picture and/or video footage. I further understand that no royalty, fee, or other compensation of any character shall become payable to me. I understand that consent to use my picture and/or video footage is voluntary. I further understand that I may at any time exercise the right to cease being filmed or photographed.

Signature: _________________________ Print Name:_____________________

Witness: _________________________ Print Name:_____________________

Date: _________________________

Please Note: If patient a minor, signature of parent or guardian is required.

Rev. Feb 2011