PHOTO RELEASE – Patient and/or Minor

I, (print name) _____,

hereby grant permission to Southwest Contemporary Women's Care (SWCWC) representatives to take and/or use photographs and/or digital images of myself and/or my minor child _____ for use in SWCWC newsletters and/or materials as follows: internal bulletin boards, electronic publications, Social Media, or the SWCWC website. I agree that my and/or my child's name and identity may be revealed in descriptive text or commentary in connection with the image(s), or I can elect NOT to reveal this same information. I authorize the use of these images without compensation to me. All negatives, prints, and/or digital reproductions shall be the property of SWCWC.

Authorization

Patient's Printed Name: _____

Signature: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

☐ My child's name and identity may be revealed in descriptive text or commentary

☐ Do not reveal my child's name and identity in descriptive text or commentary

☐ My name and identity may be revealed in descriptive text or commentary

☐ Do not reveal my name and identity in descriptive text or commentary