

DCMSAF

General Photography/Video Release

I hereby authorize Dallas County Medical Society Alliance Foundation, hereafter referred to as the "Foundation," to use any photographs or video taken of me, and my name and likeness, for such purposes as the Foundation's scrapbook, Foundation's website of publicity.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs/video. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever

I hereby release DCMSAF, Alderdge House, and any third parties involved in the creation or publication of these materials, from liability for any claims by me or and third party in connection with my participation

Authorization

Date: _____

Event: _____

Signature: _____

Printed name: _____

Email address: _____

Minor: If a minor, 18 years and younger, is depicted in the photographs/video, I represent and warrant that I am either a parent or legal guardian of the minor child, and that I have complete authority to grant release on the minor child's behalf.

Signature: _____

Printed name: _____

Email address: _____