RESTORE
PROSTHETICS ORTHOTICS CRANIAL

Consent and Release Agreement- Photography Authorization

I, _____(patient's name/guardian), hereby grant RESTORE POC permission to take photographs of myself (or my child) and/or publish my photographs for any lawful purpose, including, but not limited to, their website, social media accounts, and promotional materials, either digital or in print, in perpetuity. I also grant permission to use my name.

By signing and dating this document I authorize RESTORE POC to edit, alter, share, remix, tweak, build upon or in any way alter the photograph(s) mentioned above. I also waive any rights of privacy associated with the use of my or my child's image and name(s) for the personal or commercial purposes outlined above.

_____ _____

Signature & Date

_____ _____

Printed Name