

Family Health Network

Photo Release Form

Family Health Network (FHN) can use my photo for all publications. FHN can use my photo for the website. I will not receive payment or other incentives for my photo.

I agree that my photo will become property of FHN. My photo will not be returned to me. I allow FHN to edit and publish my photo. FHN can use my photo to promote FHN or for any lawful purpose. I cannot approve the final product (written or electronic). I do not have any right to monies related to the use of my photo.

Family Health Network is free from all claims, demands, and causes of action to me or any other person acting on my behalf.

I am 18 years of age. I have read and agree with this photo release form.

(Signature) (Date)

(Printed Name) (Date)

If you are under the age of 18, a parent or guardian must sign:

I am the parent or guardian of _____, and allow him/her to participate.

(Parent/Guardian's Signature) (Date)

(Parent/Guardian's Printed Name)

