

PATIENT PHOTOGRAPH RELEASE FORM

**New River Family Wellness, PLLC
420 East Second Street, West Jefferson, NC 28694**

Description of Photograph(s)

Authorization and Release of Photograph(s)

I understand my photograph(s) as outlined above (the "Photograph(s)") and made on behalf of New River Family Wellness, PLLC (hereinafter called "The Practice") may be used in connection with publicizing and promoting The Practice. I authorize The Practice to use my name, brief biographical information, testimonial (with appropriate signed testimonial release form), and the Photograph(s) as defined on this form.

I hereby irrevocably authorize The Practice to copy, exhibit, publish or distribute the Photographs for purposes of publicizing The Practice's services or for any other lawful purpose. These Photographs may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I agree that I will make no monetary or other claim against The Practice for the use of the Photograph(s).

In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my Photograph(s) appear(s).

I hereby hold harmless and release The Practice from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I have read the authorization and release information and give my consent for the use of my testimonial as indicated above.

Signature of Member

Name of Member (printed)

Email: _____

Address: _____

City, State, Zip: _____