Media Release

Permission for Photographing and/or Filming

Name

Address

Phone

Email

I (Name) authorize Dr. Schmelzer, Craniofacial MD, Jakob Marketing Partners and/or news agencies to use photography, slides, films, videotapes, recordings, or other means of recordings and/or communication referring to me for the following purposes: (check all that may apply)

_ News stories for television, radio, newspaper, magazine or other media

_ Advertising material for Dr. Schmelzer to be placed on television, radio, newspaper, magazines, brochures, direct mail pieces or other media.

_ Movies or other commercial purpose

_ Other _____

I consent to the use of my name, likeness, voice, etc for such purposes, and I release all officers, agents and employees from all claims of liability with respect to the showing, use or dissemination of such material.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. I can get a copy of this form emailed to me after I sign it.
3. I understand that this agreement does not expire.

Signature

Date

When subject is a minor or unable to sign, person authorized to consent:

Signature

Date

Witness Signature

Relationship

☐ By checking this box you aknowledge that the above name is your digital signature and are complying to any agreements, rules, and/or regulations associated with this document.

Rodney Schmelzer, MD *Plastics, Craniofacial & Reconstructive Surgeon (certified by the Board of Plastic Surgeons)*

p: 801-743-0700 | f: 801-743-0701 | e: info@craniofacialmd.com | w: www.craniofacialmd.com