ST. JOHNS RIVER
RURAL HEALTH NETWORK
Support Connect Improve

CONSENT, PERMISSION AND RELEASE FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of

(print name)______________________________________, age (if minor) ________.

I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by the St Johns River Rural Health Network and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: ____

Address: ____

Telephone Number/Email address: ____

Signature of Subject: ____ Date: ___________________

Required if Subject is under age 18:
Name of Parent/Legal Custodian: ____

Signature of Parent/Legal Custodian: _______________________________________

Witness Name: ____

Witness Signature: ____

Date: ____________________

☐ I am revoking this consent.
I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold the Department of Health responsible for instances of these violations.

Signature: ____ Date: _________________