NATIONAL SCOLIOSIS CENTER/3-D BODY IMAGING, LLC

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Photograph & Video Release Form

I hereby grant permission to National Scoliosis Center/3-D Body Imaging, LLC (NSC/3D) the rights of my image, likeness and sound of my voice as recorded on audio, video tape and still images without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- ☐ Marketing material
- ☐ Educational presentations and/or courses
- ☐ Conference presentations
- ☐ Informational presentations
- ☐ **National Scoliosis Center Internal use for treatment only (PT patients please check here)**

By signing this release I understand this permission signifies that photographic or video recordings of me/ my child may be electronically displayed via the Internet or in the public educational setting.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of your (your child's) treatment at NSC/3D.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for the purposes listed above on behalf of NSC/3D.

______ I decline NSC/3D permission of any Audio/Visual rights.

Patient's Full Name____

Street Address/P.O. Box____

City ______________________________Postal Code/Zip Code____________________________________

Phone ___________________________________ Fax ____

Email Address____

Signature____Date_________________________

If this release is obtained from a patient under the age of 18, then the signature of that patient's parent or legal guardian is required.

Parent's Signature____ Date__________________________