PRACTICE NAME _____

Photo release form

NAME OF PATIENT/GUARDIAN _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____

To be signed by the Patient or Guardian

I give permission for my photograph, video image, and/or voice to be reproduced, used, and/or published for the purpose of promoting and documenting the Centering model. Photos may be shared with the Centering Healthcare Institute for this purpose.

I make no claims or demands about the use of these images or recordings.

I am the responsible person to sign this waiver on behalf of myself or my child(ren), and I have read and understand this binding document.

SIGNED _____

RELATIONSHIP _____ DATE _____