

Media Release Form

Date: _____

I, the undersigned, hereby authorize Dr. Wendy Dickerson, NMD, affiliate of Valley Natural Medical Center and Glow Medical Aesthetics, to photograph me and to make photographic reproductions. By signing this form, I hereby authorize the use of any such photographic reproductions of me for any purpose, including, but not limit to educational, other public media, and advertising purposes as may be deemed appropriate be Dr. Wendy Dickerson, NMD. I understand that I may be identifiable from such photographic reproduction. I release all named entities from any and all claims arising out of or resulting from my appearance; and I waive all rights of copyright or ownership in or to the resulting educational/informational/advertising materials or photographs which relate to me.

I hereby certify that I have read the forgoing and fully understand the meaning and effects thereof, and intending to be legally bound, sign below.

Agreed and accepted by:

Print Name _____

Treatment _____

Signature & Date _____

Witness Name & Date _____