PHOTO RELEASE AUTHORIZATION

I, _____, authorize and release, in part or in whole,

photographs or electronic images of myself and or personal belongings to be used by

_____ and/or others, with consent, for the

purpose of marketing, illustration, advertising, publications, and promotion of the company's business products and/or services.

I also give consent to the use of my name in any newsletter, newspaper, television, radio medium, online website, social media sites, etc.

☐ YES ☐ NO

I understand that by granting the authorization(s) above, I waive all rights of ownership and compensation for the use of such images and/or statements. I understand such images and/or statements may be published via print and/or electronic media for the purposes of marketing, advertising or promoting products and/or services of the family.

I understand that this Authorization and release may be revoked at any time upon written notice to the facility, except to the extent facility has already acted in reliance upon the Authorization and/or Release

RESIDENT IDENTIFICATION REQUIRED PHOTO

I understand the requirement and authorize the facility to take a POLAROID or DIGITAL type picture to be used for identification purposes for my medical file.

_____ _____

Resident Signature Date

_____ _____

Responsible Party Resident Signature Date

_____ _____

Manager's Signature (or Authorized) Date