AUTHORIZATION TO USE PATIENT PHOTOGRAPHS OR LIKENESS

Patient Name:	Date of Birth
Patient Address:	Patient Identification No:
	Patient Representative:

I, or my authorized representative, authorize that my photograph (or other likeness) which I provide, and other identifying information that is included in, on or with my photograph, including my name, be posted by GPM Pediatrics in the public areas of the office of GPM Pediatrics, PC.

I understand that:

1. GPM Pediatrics, PC is not responsible for any reproduction and circulation of my photographs or of my likeness and I hereby release GPM Pediatrics, PC, its officers, directors, agents, employees and physicians from all liability and all claims of any nature whatsoever pertaining to the photograph(s) and associated information about me.
2. This authorization shall expire on _____. I have the right to revoke this authorization at any time by writing to GPM Pediatrics, PC, but understand that any revocation will be ineffective with respect to any action taken based on this authorization.
3. The photos I submit to GPM Pediatrics, PC become the property of GPM Pediatrics, PC and GPM Pediatrics, PC is under no obligation to destroy or return the photographs to me following the expiration or revocation of this Authorization.
3. Signing this authorization is voluntary.

Signature of patient or authorized representative: _____	Date:
Witness Statement and Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative. _____	Witness' name and title: _____ Date: