

NORTH CAROLINA MEDICAL SOCIETY
PHOTOGRAPHY/FILMING RELEASE FORM

I (print name) _____, knowingly consent to the photographing, recording, and/or videotaping of myself and/or my child, (print child's name, if applicable) _____. I understand that the photo/filming is being done for the use of the North Carolina Medical Society and its Foundation. I waive any right, title, and interest that I may have in such photo/filming and agree to its use by the North Carolina Medical Society and its Foundation for any purpose(s) it deems necessary.

I wish to place the following restriction(s) on the use of these photographs, recordings, or video tapes:

Signature _____ Date _____

Name (Please print) _____

Address _____

Witness Signature _____ Date _____