

NAME: _____ TODAY'S DATE: _____ DATE OF BIRTH: _____ AGE: _____

**AUTHORIZATION AND CONSENT TO PHOTOGRAPH,
RECORD INTERVIEW & PUBLISH**

I authorize Fill Centers USA, or other persons appointed by Fill Centers USA, to photograph, record, conduct media interviews, and obtain testimonials or other written documentation, regarding

Patient's Name

I agree that the photographs, testimonials, radio or television broadcast tape, or other video, audio and written materials may be used in publications or in broadcast format with radio or television. I agree that Fill Centers USA may use and permit other persons to use the negatives or prints prepared from such photographs for such purposes and in such manner as Fill Centers USA may deem appropriate.

I understand and agree that the photographs, recording, and/or publication may reveal the patient's identity. I agree that the photographs may be used for any purposes including, but not limited to, dissemination to health professionals and members of the public for education, treatment, research, scientific, public relations, promotional and charitable purposes, and that such dissemination may be accomplished in any manner and that such use is subject only to the following limitations:

I have entered into this agreement in order to assist scientific treatment, educational, promotional, public relations and charitable goals, and hereby waive any rights to compensation for such uses by reason of the foregoing authorization; and I and my successors or assigns hereby hold Fill Centers USA, its administrators, directors, officers, employees or agents and related entities harmless from and against any claim for injury and compensation resulting from the activities authorized by this agreement.

The term "photograph" as used in the foregoing agreement, shall mean motion picture or still photography in any format, as well as video tape, video disc, and any other mechanical means of recording and reproducing images.

This authorization is effective indefinitely.

By signing below, I acknowledge that I have read and understand the above and agree to the terms of this agreement.

Dated: _____, 20__ Hour _____ am/pm Signature: _____

If signed by other than patient, indicate relationship:

Authorization to Participate in Media Interview

I consent to participate in an interview with _____ and I understand this will involve the disclosure of health care information about me. I agree to hold Fill Centers USA harmless from any and all liability arising from this interview and any news article printed or broadcast as a result of the interview.

By signing below, I acknowledge that I have read and understand the above and agree to the terms of this agreement.

Dated: _____, 20__ Hour _____ am/pm Signature: _____

If signed by other than patient, indicate relationship: