CONSENT, PERMISSION AND RELEASE
FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to WESTERN COMMUNITIES INTERNAL MEDICINE SOLUTIONS, LLC to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of (print name) _____ _____, age (if minor) _____.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by WESTERN COMMUNITIES INTERNAL MEDICINE SOLUTIONS, LLC and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing.

I acknowledge that WESTERN COMMUNITIES INTERNAL MEDICINE SOLUTIONS, LLC is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released.

WESTERN COMMUNITIES INTERNAL MEDICINE SOLUTIONS, LLC has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold WESTERN COMMUNITIES INTERNAL MEDICINE SOLUTIONS, LLC its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name:

Address:

Telephone: _____ Email address:

Signature:

_____

Date: _____

Name of Parent/Legal Custodian (under age 18):

_____

Signature of Parent/Legal Custodian (under age 18):

_____

Witness Name:

_____

Witness Signature:

_____ Date:

_____

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold **WESTERN COMMUNITIES INTERNAL MEDICINE SOLUTIONS, LLC** responsible for instances of these violations.

Signature:

_____

Date: _____