Diane Ryan, P.T.

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Patient Photograph Release Form

Patient Name____ Date of Birth_________________

Photograph Consent and Release

I hereby acknowledge that I will be photographed and/or videotaped during my physical therapy treatment. I give my consent for Diane Ryan, P.T. to use the photographs under one of the following circumstances:

Please initial <u>one</u> of the following:

________ Medical Care Only: The photographs taken of me can be only used for my medical care and will be kept confidential with my personal medical history.

________ All Media: Photographs and/or videos taken of me regarding my medical care received from Diane Ryan, P.T. may be used in print and on the company's website in order to inform the public about physical therapy. I give my consent as a voluntary contribution in the interest of public education and my consent is subject to the condition that I am not identified by name during their use.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

Signature (Parent or guardian if patient is under 18) Date