



ANTELOPE VALLEY
HOSPITAL
A facility of Antelope Valley Healthcare District

Photo and Promotional Release Consent Form

I hereby consent to be photographed, videotaped or filmed by representatives of Antelope Valley Hospital for purposes of publication, display or broadcast (print, web, digital display and all other forms of media).

I agree that such photographs, films, or video and/or any reproductions of same in any form, are the property of Antelope Valley Hospital, and I relinquish any present or future claim for reimbursement for said photographic or film reproduction of my likeness.

I hereby release Antelope Valley Hospital, its affiliates, employees, representatives and agents from any and all claims, demands, costs and liability that may arise from the use of these recordings, photographs, videotapes or films, and/or any reproductions of same in any form, as described above, arising out of being recorded, photographed, videotaped or filmed.

I understand that I may revoke this authorization at any time by providing written notification to Antelope Valley Hospital, 1600 West Ave. J, Lancaster, CA 93534 Attn: Marketing and Public Relations Department. However, the revocation will not be valid if Antelope Valley Hospital has taken action in reliance on this authorization. This authorization expires only upon written notice from consentor.

I acknowledge that I have read this consent form in its entirety, or it has been read (or translated) to me, and I have had the opportunity to ask questions about it and understand it.

Date: _____

Name (print):

*Parent or Legal Guardian name (print):

Signature:

*Parent or Legal Guardian signature:

**Parent or Legal Guardian name and signature required for individuals under 18 years of age.*