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PHOTO RELEASE CONSENT

Purpose of Consent: By signing this form, you are consenting to allow **Ilyas Munshi, M.D.** and any associated staff members to use and distribute your photo along with your patient testimonial.

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I hereby grant permission to allow **Ilyas Munshi, M.D.** to use the photograph of me shown below in conjunction with my patient testimonial. I hereby agree and acknowledge that my photo will be released to the public via public relation efforts of **Ilyas Munshi, M.D.** I further acknowledge and agree that my photo may be used by the media.

I waive the right of prior approval and hereby release **Ilyas Munshi, M.D.** from any and all claims for damages of any kind based on the use of my photo or information contained in my testimonial.

By signing below I agree and acknowledge that I have read and understood the above release and agree to all terms described. I am of legal age and freely sign this release.

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Signature   Date

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Print Name

Please provide your contact information:

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