MEDIA RELEASE FORM

I, _____, consent for photographs to be taken by First Coast Wound Care, LLC through a provider or a representative. I grant permission for photographs of (Initial by desired choice):

_____ WOUND ONLY _____ WOUND AND FACE _____ WOUND AND NAME

_____ WOUND, FACE AND NAME

I, _____, grant permission to First Coast Wound Care, LLC and its associates to use my image(s) for use in social media publications, general publications, advertising purposes i.e. brochures, magazines, newsletters, websites and/or affiliates, email blasts, videos, and any other purposes/platforms First Coast Wound Care, LLC desires. I understand these photos are property of First Coast Wound Care, LLC and I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image(s).

Print:_____ Date:_____

Signature:_____ Date:_____