Patient Photograph and Video Consent and Release Form

First Name	M.I.	Last Name
Today's Date	Date of Birth	Social Security Number

I, being Parent/ Guardian of ___________________________________ *(Insert full name of minor)* hereby consent and authorize the above mentioned minor to be photographed and/or videotaped by **A New Step Prosthetics, LLC** for :

❑Yes ❑No Insurance Authorization or Payment
❑Yes ❑No Shared with your Healthcare Providers
❑Yes ❑No Training
❑Yes ❑No Advertising
❑Yes ❑No Promotional
❑Yes ❑No Education purposes *about orthotics and/or prosthetics services, medical equipment, medical items and/or treatment outcomes in professional medical journals, periodicals, newspapers, our company's website, company brochures and other marketing materials.*

- I understand that use of patient photograph(s) and/or videotape(s) may be used to educate, train and/or promote awareness to parents, staff and other professional healthcare providers.
- I understand that the original print(s), negative(s) and/or video(s) will be maintained and stored in the patients' medical record at **A New Step Prosthetics, LLC**. All such original print(s), negative(s) and/or video(s) will be the exclusive property of **A New Step Prosthetics, LLC**.
- I understand that I have the option to withdraw my consent and I have the right to do so at any time.
- I understand that I must submit my option to withdraw this consent by sending a letter directly to the administrative office of **A New Step Prosthetics, LLC.**
- I release **A New Step Prosthetics, LLC** and its Board of Directors, Officers, Employees and Representatives from any and all liability these photograph(s) and/or videotape(s).
- I understand that there will be no financial or other payment for the use of these photographic image(s) and/or videotape(s).

By signing this consent form, I confirm that I have read, understand and agree to all the above terms and conditions. I also represent that I am over the age of 18 years of age and/or I am the parent or legal guardian of the above mentioned minor.

My relationship to the above mentioned patient is: ❒Self ❒Parent ❒Legal Guardian

______________________	______________________	______________________
Patient's Signature	Patient's Printed Name	Date Signed
______________________	______________________	______________________
Parent/Guardian Signature	Parent/Guardian Printed Name	Date Signed

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