

**Video/Photo Release Form**

I hereby consent to and authorize the use and reproduction by you as a representative of The University of Texas at Tyler, School of Health Professions, or anyone authorized by you, of any and all photography with will be taken by myself, for use by The School of Health Professions for the purpose of the Public Health Week Photo Contest. I understand that my photos may be displayed in the School of Health Professions.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information:

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Mailing Address

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City, State, ZIP

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Phone Email Address