

To: Accredited Medical Equipment Providers of America
20815 N.E. 16th Avenue – Suite B-32, Miami, FL 33179
Office: 305/654-5957 Fax 1-866-322-2060 www.amepa.us

PHOTO RELEASE FORM

I hereby grant the Accredited Medical Equipment Provider of America (AMEPA) permission to use my likeness in a photograph in any and all publications, including website entries, without payment and any other consideration.

I understand and agree that these materials will become property of the Accredited Medical Equipment Providers of America and will not be returned.

I hereby irrevocably authorize AMEPA to edit, alter, copy exhibit, publish or distribute this photo for purposes of publicizing AMEPA's efforts and programs or for any other lawful purpose. In addition I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph. I hereby hold harmless and release and forever discharge AMEPA from all claims, demands and causes of action which I, my heir, representatives, executors, administrators, or any other person acting on my behalf or on behalf of my estate have or may have by reason of this authorization. I am over 21 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understanding the contents, meaning and impact of this release.

(Signature of Party Photographed)

(Date)

(Name of Party Photographed)

If the person signing is under age 21, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

(Parent/Guardian's Signature)

(Date)

(Parent/ Guardian's Printed Name)