Hackensack Meridian
Pascack Valley Medical Center

*This Form to be used in conjunction with the Form entitled "***Authorization to Use and Disclose Images, Voice Recordings and/or Testimonials**"

APPEARANCE, PHOTOGRAPHY, MEDIA AND TESTIMONIALS CONSENT AND RELEASE

I, the undersigned, authorize **Pascack Valley Medical Center** and its affiliates, parents, subsidiaries, licensees, successors, designees, and assigns (collectively, "**Provider**") to videotape and/or photograph me and record my voice, conversations, and sounds, including the right to publish, distribute, display, perform, exhibit, transmit, copy, regarding Provider and its services, employees or staff, and including photographing, taping, and/or recording my medical condition(s) or treatment(s), or biographical information I may provide (collectively, the "**Materials**"). I understand that for purposes of this Appearance, Photography, Media and Testimonials Consent and Release (this "**Consent**"), the terms "image," "voice" and "photograph" encompass still photographs, digital images, audiotapes and any other method to reproduce or edit my likeness, image or voice, now known or hereafter developed.

I expressly understand and agree that Provider shall be the owner of the results and proceeds of such Materials for any and all purposes whatsoever in perpetuity, free and clear of all claims whatsoever by me and/or on my behalf, with the right, throughout the world, an unlimited number of times in perpetuity, to copyright, to use, to publish, and to license others to use in any manner, including on the Internet or other digital means, all or any portion thereof, free of any payment, royalty, or other compensation of any kind to me.

I represent that any statements made by me during my appearance or in the Materials are true to the best of my knowledge and that neither they nor my appearance will violate or infringe upon the rights of any third party. I hereby waive any right of inspection or approval of the Materials and my appearance in such Materials and the uses to which such Materials may be put. I agree that the Materials may be edited in the sole discretion of Provider and that Provider is under no obligation to use the Materials. I acknowledge that Provider will rely on this permission potentially at substantial cost to Provider and hereby agree not to assert any claim of any nature whatsoever against anyone relating to the exercise of the permissions granted hereunder.

I hereby forever release and discharge Provider, and its respective members, officers, employees, customers and representatives from any and all claims, demands, actions, liabilities and damages whatsoever arising out of or attributable to, in whole or in part, the use of the Materials.

I hereby acknowledge that neither Provider nor any of its agents or employees have made any representations or warranties of any kind with respect to any medical or other advice or information that I may receive in connection with my appearance and that I have not relied on any such representations or warranties in agreeing to participate in the recording of my voice and/or likeness as described above.

I am signing this Consent as my voluntary act and deed, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs and assigns. I understand that this Consent will be signed contemporaneously with the form entitled Authorization to Use and Disclose Images, Voice Recordings and/or Testimonials (the "**Authorization**"), and I agree that in the event of conflict between the two documents, the terms of the Authorization shall govern.

Signature of Individual or Legal Representative: _____

Print Name: _____ _____Date: _____

Relationship of Legal Representative to Patient (e.g., parent, guardian):
_____