



## Consent for Use of Photography

### Contact Information (all fields are required)

Name (print): \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

Brief description of photograph (name/year/background):

\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, the undersigned, hereby give my consent to Sheridan County Health Complex (SCHC) for use of the attached photograph(s) described below. I consent the photograph is mine to release and I understand the photograph may be used/displayed on the SCHC website. I acknowledge that I am at least 18 years of age.

I hereby acknowledge that I will not receive any compensation for use of the attached photograph, and that SCHC is not required to use/display the photograph.

The undersigned and his/her successors hereby hold the above named facility harmless against any claim for injury or compensation resulting from the activities authorized by this consent.

**By typing your name below, you agree this is valid as your signature\***

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\*If you are not submitting this form electronically, please sign and date