Travis County Medical Alliance

TCMA Photo Release Form

Event: _____

Date: _____

I give permission for the photographs of the following persons listed below to be posted on the website/ social media sites of Travis County Medical Alliance. I understand these photos can be viewed by anyone, but no identifying information will be displayed.

I am over 18 years old, and I give permission for my image to be published.

Print Name: _____

Signature: _____

_____

I am the parent or legal guardian of the following child(ren) under 18 years of age, and I give permission for their images to be published.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Adult's Name (Print): _____

Adult's Signature: _____