ERIE COUNTY DEPARTMENT OF HEALTH
PHOTO RELEASE FORM

Subject: _____

Location: _____

Date: _____

I grant the Erie County Department of Health, its representatives and employees the right to take photographs of me and my property in connection with the above-identified subject. I authorize the Erie County Department of Health, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that the Erie County Department of Health may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Printed name: _____

Signature: _____

Date: _____

Organization Name (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Signature, parent or guardian (if under age 18): _____