Photograph/Media Consent And Release

Patient Name	:	sandhya rani				Emirates ID	:	784-1996-9294842-7
File No	:	7	DOB	:	2023-10-09	Nationality	:	Other
Gender	:	Female	Doctor's Name	:	Shilpa Sandhya	Date	:	2023-12-28

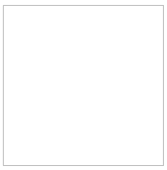
I hereby consent and authorize **AUSTRALIA MEDICAL CENTRE** to take photographs or motion pictures of me; or to produce videotapes, audiotapes, closed circuit television programs, web casts, or other types of media productions that capture my name, voice, and/or image (any of the foregoing types of media are called the "Materials" in this Consent and Release form).

I authorize **AUSTRALIA MEDICAL CENTRE** to copyright the Materials, and I authorize **AUSTRALIA MEDICAL CENTRE** to use, reuse, copy, publish, display, exhibit, reproduce, license to third party, and distribute the Materials in any educational or promotional materials or other forms of media, which may include, but are not limited to university publications, catalogs, articles, magazines, recruiting brochures, websites or publications, electronic or otherwise, without notifying me..

I also agree that **AUSTRALIA MEDICAL CENTRE** may identify me by name, course of study, and such other identifying information as class year, graduation date, hometown, etc. (If the person does not wish to be identified by name, etc., please have them cross through this sentence, and initial year.)

I agree that I am participating on a voluntary basis and I will not receive any payment from **AUSTRALIA MEDICAL CENTRE** for signing this release or as a result of any publication of the Materials.

I represent that I am at least 18 years of age, or if not, that I have secured the signature of my parent or legal guardian.

Sign here, only if all of your questions have been answered to your satisfaction		
Patient	witness	Doctor
		
Patient Name sandhya rani Date 2023-12-28	Witness Name s Date 2023-12-28	Doctor's Name Shilpa Sandhya Date 2023-12-28