



DERM|sa
MEDICAL
SURGICAL
COSMETICS

I, _____ do hereby voluntarily participate and give authorization for Earl E. Ferguson, MD, his representatives and employees of Dermatology Associates of San Antonio to take photographs of me. I authorize Dr. Ferguson and/or Dermatology Associates of San Antonio to publish the same in print and or/electronically on any of his social networking, websites or marketing materials as well as any scientific publications, exhibits, lectures or articles.

I agree that Dr. Ferguson and/or Dermatology Associates of San Antonio may use such photographs of me for any lawful purpose, including publicity, illustration, advertising, marketing and web content as well as any scientific publications, exhibits, lectures or articles.

I understand that I will not be identified by name in any such use of these photographs.

I waive any right to compensation for the above uses. I hold Dr. Ferguson, Dermatology Associates of San Antonio and their designees harmless from and against any claim or injury or compensation resulting from the activities authorized by this agreement.

The term "photograph," as used in this agreement, shall mean motion picture or still photography in any format, as well as videotape, video disc, and any other mechanical means of recording and reproducing images.

I have read and understand the above:

SIGNATURE: _____

PRINTED NAME: _____

DATE: _____

WITNESS: _____