Ashley Surgery Photograph Permission Form

I give permission for Ashley Surgery and/or Ashley Surgery Patient Participation Group to use this/these photograph(s) of me, or in which I may be included with others, in publications & advertisements to illustrate and promote walking and the health walks.

Details of person in photograph

Name: _____

Contact details (telephone and/or email address)

_____

_____

I declare that I am over the age of sixteen years and that I have read the above and completely understand the contents.

Signature: _____

Or

I declare that the individual(s) photographed is under sixteen years and that I am the parent or duly authorised representative and that I have read the above and completely understand the contents.

Signature of parent or duly authorised representative: _____