WAYNE MEMORIAL
HOSPITAL

Release of Photographic Authorization

Authorization is hereby granted Wayne Memorial Hospital to photograph and release such photographs of the individual(s) listed below for the purpose of medical education, public information or publicity in the interest of the Hospital.

Individual(s) to be photographed:

Name	Address
Name	Address
Name	Address

Signature of person granting authorization: _____

_____
Address

Self
Wife
Husband
Mother
Father
Guardian

Witness: _____

Date: _____

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