

PARTICIPANT/PATIENT CONSENT AND RELEASE

By completing and signing this form, I agree to give the Scoliosis Research Society and any organization or individual acting under its authority or permission, all rights to the use of biographical narrative information including personal health information and photographic and/or digital recording of my likeness, which were submitted by me to the SRS.

I understand that the biographical information submitted by me to the SRS will be used to write a biography of me, which will include the information I provided on the 2010 SRS Vignette Form. This biography and the photographic recording will be highlighted on the SRS web site and potentially published by SRS.

I authorize the reproduction, use for copyright, broadcast, transfer, exhibition and/or distribution of my biographical information, recording (including electronically), and photographs or video taken of me, for educational and publicity purposes in connection with the SRS. I understand that in this Agreement, recording means any reproductions or any likeness made by any process, photographic or electronic, in black and white, or color, or any combination of these processes, along or in conjunction with other persons, or based on any additions, alterations, retouching or compositing with other reproductions of any kind.

Further, I give up all rights of inspection or approval and irrevocably release all authorized users from all claims or demands, which I may or can have on account of the use or publication of the above-mentioned photographic recording, biographical and health information. This agreement is a perpetual, irrevocable license that I understand I am authorizing as a charitable contribution in furtherance of non-for-profit educational, research and advocacy activity.

I certify I am (_____) under (_____) over 18 years of age.

I have read the foregoing release, authorization and agreement before signing below, and I fully understand the contents.

Participant/Patient Name (Please print/type)

Date

Signature of Patient

I certify that I am the parent and/or guardian of the person listed above, a child under the age of 18 years of age, and certify that I understand and agree to the terms of this consent and release.

Signature of Parent/Guardian

Date

Address