

Drexel University College of Medicine Multimedia Consent and Release

I hereby authorize and give permission to Drexel University College of Medicine, and those acting under its direction to:

- 1. Record my testimonial about Drexel University College of Medicine's [NAME OF PROGRAM] in writing, videotape, audiotape, film, photograph, or any other medium.
- 2. Use my name, likeness, words, and biographical material in connection with the testimonial.
- 3. Publish, exhibit, copy or use such recording and material about me, in whole or in part, in any media, new known or later developed, without any restriction, for any promotional purpose that Drexel University College of Medicine may deem appropriate.
- 4. I understand I will not receive any payment of any other type of compensation for this use.

Name:	
Address:	
Telephone:	
Signature (or signature of parent/guardian if student is under 18 years of age):	
Name of parent	t/guardian if applicable:
1	
Date:	