



*Establishing and Advancing the
Chiropractic Family Wellness Lifestyle Worldwide*

MODEL RELEASE

I understand that Dr. _____ is working towards a recognized status of continuing education with the ICPA, Inc. As part of that process, video-taping patient exams and classes is a necessary requirement.

I hereby give permission to Dr. _____ to videotape me/ my child. The only copy of this recording will be forwarded to the ICPA Academic committee (at the address below) who will review this footage for clinical excellence. The doctor will not retain a copy of the footage. I understand that my/our names will not be associated with the film when submitted. Any conversation in the process is kept strictly confidential. All footage will be permanently destroyed once the doctor's submission has been reviewed and graded.

Please fill out for each person appearing in the video.

1. Print Name: _____

Signature: _____ Date: _____

2. Print Name: _____

Signature: _____ Date: _____

If Model is under 18: I, _____, am the parent/legal guardian of the individual named above, I have read this release and approve of its terms.

3. Print Name: _____

Signature: _____ Date: _____

4. Doctor's name: _____

Signature _____ Date: _____