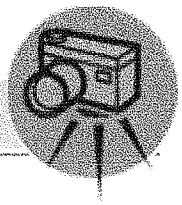
Release Form for Media Recording



I, the undersigned, do hereby consent and agree that **VEIN SPECIALTY CENTER**, it's employees, or agents have the right to take photographs or digital recordings of me for the purpose of insurance documentation, educational uses, or promotional materials. I understand that my identity will be maintained as confidential in accordance with the HIPPA PRIVACY ACT.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell Phone: _____

Signature: _____

VEIN SPECIALTY CENTER

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