

ARKANSAS HOSPICE

AGREEMENT, RELEASE INFORMED CONSENT

I, _____

I hereby authorize the use of my (or my loved one's) name, photograph, likeness, audio or video recording of myself (or my loved one), or a written statement by me (or my loved one), for use by Arkansas Hospice for publicity purposes.

I do further release Arkansas Hospice and each of their officers, directors, employees, and representatives from any claims arising out of the use of my or my loved ones name, photograph, electronic recording, television transmission or video tape or written statement.

This Agreement shall be binding upon my heirs, executors, estate, transferee and assigns.

DATE _____ SIGNATURE _____

NAME _____

ADDRESS _____