



**PERMISSION TO PHOTOGRAPH
AND/OR RECORD AUDIO AND VIDEO**

I, _____, hereby authorize ***NORTH AUSTIN PREMIER SLEEP CENTER***, or their representative, to take photograph(s) and/or record audio and video of

Name of Patient

I understand that such photograph(s) and/or video recordings may be used for clinical or educational purposes or in the event of legal action. The sleep center and trustees of *North Austin Premier Sleep Center* and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s) and/or video recordings.

The undersigned also hereby transfers and assigns to *North Austin Premier Sleep Center* the right to copy the materials in whole or in part. No use of the material for educational purposes will identify me by name.

Check here _____ if you DO NOT authorize use for educational purposes.

Signature (patient or guardian)

Date

Relationship to Patient if Guardian _____

Witness

Date

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