HEALTHWELL FOUNDATION®

When health insurance is not enough.®

Patient Waiver

____ I DO NOT grant HealthWell the right to use my Image in its outreach efforts.

____ I DO grant HealthWell the right to use my Image in its outreach efforts, and also grant HealthWell my express permission to use this Image, and any other Image(s) I choose to share with HealthWell, without payment or any other consideration from HealthWell. I understand and agree that the Image(s) will become the property of HealthWell and will not be returned to me. I also understand and agree that HealthWell may edit, alter, copy, exhibit, publish or distribute the Image(s) for purposes of publicizing HealthWell and its programs as HealthWell may deem desirable or appropriate in its discretion, and that I will not have any right or opportunity to approve the finished product before it is released. I hereby hold harmless, release and forever discharge HealthWell and its officers, directors, employees, agents, successors and assigns from any and all claims, demands, and causes of action which I, or my heirs, personal representatives, executors, administrators, agents, successors or assigns, have or may have by reason of this authorization.

_____	_____
Signature of Applicant or Personal Representative	Date
_____	_____
Applicant's Name	
_____	_____
Personal Representative's Name	Relationship to Applicant