Lincoln Memorial University

Lincoln Memorial University-College of Veterinary Medicine
Media Release

Lincoln Memorial University (LMU), Lincoln Memorial University-College of Veterinary Medicine (CVM), and Student Name Here (Student) seek the right and permission to take and use photographs, videos, and/or audio (Media) of the care and treatment of the Owner's pet/animal by Veterinarian/Practice Name Here (Veterinarian/Practice) for clinical education of its students. Media obtained will be stricken of all identifying information and veterinarian/Owner/Pet/Animal confidentiality will be maintained, unless release of identifying information is expressly authorized below. Media obtained may be used, reproduced, and distributed for educational purposes in various formats including, but not limited to, student papers, case presentations, journal articles, and other methods used for transmission of educational materials.

By signing this release, you agree to allow LMU, CVM, and Student to photograph, video, and/or audio record the care and treatment of Owner's pet/animal and to use, reproduce, and distribute the Media as indicated above.

By signing this release, you agree to forever discharge and release Lincoln Memorial University, Lincoln Memorial University-College of Veterinary Medicine, and Student Name Here (Student) from any and all claims and demands arising out of or in connection with the use, reproduction, and distribution of the Media obtained.

By signing this release, you affirm that you are of full age and have the right to contract in your own name.

I have read the above and fully understand the contents. This release shall be binding upon me, my heirs, assigns, and legal representatives.

____
Pet/Animal Owner - Print First and Last Name

____
City and State Zip Code (optional)

____
Email Address (optional)

*Optional: I give permission to release identifying information of myself and my pet/animal.
Initials: _______

X____
Pet/Animal Owner Signature Date

____
Veterinarian or Authorized Representative - Print First and Last Name

*Optional: I give permission to release identifying information for myself and my clinic.
Initials: _____

X____
Veterinarian or Authorized Representative Signature Date

_______________________________________ X____________________________________
Name Witness: LMU-CVM Student - Print First and Last LMU-CVM Student Signature Date