Video Release Form
Bute Medical School
St Andrews

Person Filming: _____

Video Title: _____

Production Date: ___/___/___

Production Location(s): _____

I authorize the Person Filming to record and edit into his or her Video and related materials my name, likeness, image, voice, interview, and performance. The Person Filming may use and authorize others to use all or parts of the Video. The Person Filming shall own all right, title, and interest in and to the Video, including the recordings, to be used and disposed of without limitation as the Person Filming shall in sole discretion determine.

Note: Persons appearing under the age of 18 must also have a parent/guardian sign the form in the designated area, indicating that he or she is a parent/guardian of the above signed minor and also agrees to the terms presented above.

Name (above 18)	**Address**	**Signature**	**Date**
_____	_____	_____	__/__/__
_____	_____	_____	__/__/__
_____	_____	_____	__/__/__
_____	_____	_____	__/__/__
_____	_____	_____	__/__/__
_____	_____	_____	__/__/__

Minors

Minor_____	_____	_____	__/__/__
Parent/Guard._____	_____	_____	__/__/__
Minor_____	_____	_____	__/__/__
Parent/Guard._____	_____	_____	__/__/__