Release and Waiver of Patient (USA Clinic)

Clinic hosted by VOSH-_____

Location: _____

Date(s): _____

I recognize and acknowledge that I will be receiving free health care services today. I understand that while the volunteer professionals offer high quality procedures with good equipment, this clinic provides primary eye care and continued eye care of ongoing eye disease is not available. I understand that I might have certain medical conditions which would keep me from having the type of treatment I am requesting. I also understand that the vision care providers are volunteers, some from out of town, and are not available for follow-up care.

In consideration of the free vision care services received on the date below, for myself and anyone entitled to claim through me, I do hereby waive and release and hold harmless BOTH Volunteer Optometric Services to Humanity/International AND the above mentioned regional chapter of that organization, both referred to in this Release and Waiver as "VOSH" and any other organization or company or persons acting their behalf or sponsoring or volunteering at this clinic from any claims, demands and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have arising out of or relating to my acceptance of such free care including but not limited to medical, surgical, dental and/or vision care or other health care or medical advice, treatment or services, to the full extent permitted by law.

I grant permission to VOSH to take and release any pictures or stories about my participation in the clinic and to use my story, likeness and/or any photographs provided, in any and all of its publications, including, but not limited to, the VOSH web sites and social media, without payment or other consideration. I hold harmless VOSH from any claims, demand, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization or the use of my story, likeness, and photos.
I have read, or had read to me, and understand tan agree to all of the above.

Print patient's name:

Patient signature:

If patient is under 18 years of age, print parent or guardian's name:

If patient is under 18 years of age, signature of parent or guardian:

Date: _____