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Photo Release Form

Full Name: _____

Date of Birth: _____

Phone (Cell/Mobile): _____

Email: _____

Age: _____

Please tick relevant boxes:

___ I give permission for my photograph to be used within Revolution Combat Club for display purposes.

___ I give permission for my photograph to be used within other printed publications.

___ I give permission for my photograph to be used on Revolution Combat Club website.

___ I give permission for my photograph to be used on Revolution Combat Club social media.

___ I can confirm that I have read or been made aware of how these images will be stored within the organization.

Signature: _____

If applicable

Signature (parent or legal guardian): _____