AUTHORIZATION FOR RELEASE OF PHOTO AND INFORMATION FOR PUBLICATION

You have the right to decide if you want your child’s photograph and information that you provide on the following document to be shared with Kirby Medical Center staff, media representatives or other individuals involved in internal or external publicity. In order to protect your privacy, we require your consent before releasing any information about your child or allowing anyone to photograph, record your child on audio or video for advertising or publication.

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I authorize Kirby Medical Center and its agents to release the information specified to the following:*

\_\_\_\_\_ Kirby Medical Center’s Marketing, Public Relations consultants, and staff

\_\_\_\_\_ All forms of media including advertising, marketing, social, outdoor, and other

**I have read and understand the terms of this authorization, and I have had a chance to ask questions about its use and distributions.**

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Parent Signature Date