Interview/Video/Photograph Authorization

I/we hereby authorize my child, _____age _____, to be interviewed and/or videotaped or photographed, or to have medical information about him/her released for the purposes listed below:

Scope of use:

o Children's publications/promotional materials including print and online
o Media relations
o Website and other interactive communications
o Communications with elected officials

I/we further authorize Children's National Medical Center to release my child's name, voice, picture, likeness, and statements at any time, according to the scope of use indicated, for 5 years from today. However, I/we understand at any time during that 5-year period I/we am/are entitled to revoke that authority for future use by contacting the Public Relations and Marketing Department at 202-476-4500.

I/we hereby authorize my child's medical provider [insert name and title]_____ to by interviewed by _____ and to disclose private health information concerning my child's medical condition. I understand that this information may be used for publication in the open media. I also understand that I may withdraw my consent to this disclosure at any time through written or verbal request.

I/we understand that once the news media interviews and/or photographs my child, the media owns all rights to that footage and Children's National Medical Center has no authority over where or when it is displayed. The footage can be used how the news media sees fit throughout the world in perpetuity.

I/we waive any right of inspection or approval of my child's appearance or information or the uses to which that appearance may be put.

I/we understand Children's National Medical Center has no control of any photographs/video taken of my child by any Public Official or third party representative during a visit once they leave the premises.

I/we understand that the information is confidential, and that I/we am/are waiving the right to keep this information confidential by signing this authorization. I/we hereby release Children's National Medical Center and its entities from any claim for damages including, but not limited to, breach of confidentiality, invasion of privacy, violation of the physician-patient privilege, or violation of any District of Columbia or Federal law.

Signature:_____Printed Name:_____
Parent or Legal Guardian

Patient Name:_____Patient Birth Date:_____

Address:_____
Number and Street
_____
City, State and Zip Code

Phone number:_____Email Address:_____

Witness:_____Date:_____

Event:_____