

# SHRINERS

## AUTHORIZATION TO USE PATIENT'S LIKENESS FOR PUBLIC RELATIONS AND FUNDRAISING PURPOSES

I understand that Shriners Hospitals for Children is a charitable organization which depends upon public financial support to operate its hospitals, because it makes no charges to its patients or others for the services it renders. I also understand that \_\_\_\_\_ **SHRINERS** engage in public relations programs and fundraising programs designed to make the public aware of the hospitals' needs, which include financial support, and to inform the public of the availability of the hospitals' services.

I have been asked for permission to use photographs, audios or similar "likenesses" of myself if I am 14 or older, and/or of my child if I am the child's parent or legal guardian, in \_\_\_\_\_ **SHRINERS** public relations programs and fundraising programs, and I have been assured that permission is not required as a condition to treatment of my child by Shriners Hospitals for Children.

I wish to help \_\_\_\_\_ **SHRINERS** in its public relations and fundraising programs, and I consent to photographs, slides, television, videotape, audiotape or motion pictures (called "likenesses") being taken of \_\_\_\_\_, or parts of his or her body, for public relations and fundraising purposes, subject to the following conditions:

- (1) The last name of either the child or the parent or guardian can be used to identify the "likenesses", unless I/we have initialed here: \_\_\_\_\_.
- (2) The "likenesses" will be taken only with the consent of the attending physician and/or a hospital administrator and under conditions, and at times, as may be approved by them.
- (3) The "likenesses" will only be used in Fundraising Mailing Campaigns and Public Relations Media for five years from the date I sign this consent.

I can revoke (take back) this authorization at any time by notifying \_\_\_\_\_  
\_\_\_\_\_. However, revoking this authorization will not affect any materials that were already distributed based on my previous authorization.

I also understand that these "likenesses" may be distributed by other people (such as passing on their copy of a "likeness") and that \_\_\_\_\_ **SHRINERS** has no way to prevent this from happening.

I have been given an opportunity to ask questions about this authorization, and either I had no questions or they have been answered to my satisfaction.

I expect no payment or anything else valuable for signing this authorization. Also, this authorization as to any use of photographs, slides, television, videotape, audiotape or motion pictures will expressly release from liability to me the person obtaining the "likeness", the attending physician, the hospital and all its personnel, Shriners Hospitals for Children and affiliated corporations, The Imperial Council, A.A.O.N.M.S., Shrine Temples, their officers and members.

\_\_\_\_\_  
Father or Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother or Legal Guardian Signature

\_\_\_\_\_  
Patient's Signature (if age 14 or older)

\_\_\_\_\_  
Witness Signature

**Temple Use Only**

Patient Name: \_\_\_\_\_ F \_\_\_\_ M \_\_\_\_

Hospital: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age @ Photo \_\_\_\_\_

Orthopaedic

Burn

Spinal

Parent(s)/Guardian Names: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

Photographer: \_\_\_\_\_

Comments: