PATIENT STORY & PHOTOGRAPH RELEASE FORM

I, _____ [name of parent or legal guardian if child under 18], hereby grant permission to use the information and/or photo I am submitting of _____, age ____, for promotional purposes by Children's National Medical Center, including the Children's Hospital Foundation. Children's National may publish this content online and in print materials for five years, and it may be revised and used in part or in its entirety. I authorize the release of any health information contained in this submission and authorize the staff of Children's National Medical Center to discuss this information with physicians and other staff as necessary to verify the accuracy of the information.

Signature of Parent, Legal Guardian, or Legally Authorized Representative:

_____

- or -

Signature of Patient or Former Patient (if 18 or over):

_____

Date: _____

Printed Name: _____

Patient Name: _____

Patient Birthdate: _____

Address: _____
Number and Street

_____
City, State, and Zip Code

Phone number: _____

Email Address (optional, if you'd like to receive updates about Children's National Medical Center):

_____

Mail completed form, patient story, and photo(s) to:

Children's Hospital Foundation
Patient Stories
801 Roeder Rd.
Suite 300
Silver Spring, MD 20910

If you have any questions please call Stacy Williams or Margaret Cohen at 301-565-8500