**PHOTOGRAPY CONSENT/MODEL/MEDIA RELEASE FOR MINOR CHILDREN**

I, *(print name)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent or official guardian

of *(minor’s name)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby grant permission to

Wickenburg Community Hospital, its employees or representatives, to take and use:

□ Photographs/digital images

□ Videotape

□ Audio recording

□ Quoted remarks

in print and/or electronic media, such as but not limited to educational materials, promotional materials, radio, website, and Facebook. I further agree the minor’s name and identity may be revealed in descriptive text or commentary in connection with the image(s).

I agree that the media □ *May* □ *May Not* contact me to speak with the minor regarding said involvement in Wickenburg Community Hospital activities. I further authorize the use of these materials indefinitely without compensation to the minor or myself. All negatives, positives, prints, digital reproductions, video, and audio recordings shall be the property of Wickenburg Community Hospital.

I understand the minor and I are not spokesmen for Wickenburg Community Hospital;

I have the right to a copy of this release; I have the right to a copy of photo, article, video, audio using the minor’s name, image, quote, etc.; and I have the right to resend or limit the use of the minor’s name, image, quote, etc. at any time in writing:

Community Awareness

Wickenburg Community Hospital

520 Rose Lane, Wickenburg, AZ 85390

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

*(Date)*

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

*(Signature of Parent or Guardian)*

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

*(Phone)*

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*(Address, City, State, Zip)*