



AUTHORIZATION FOR PHOTO RELEASE

Name:	Age:	Address: Street: _____
Telephone Number:	Birth Date:	City: _____ State: _____ Zip: _____

I hereby authorize **St. Mary's Hospital at Amsterdam** to photograph, copyright, use and publish my photographic or video image or the photographic or video image of my minor child(ren) _____ (Name of Child or Children).

I understand that the photographic or video image may be produced and released in any form, in whole or in part, with such alterations and changes as **St. Mary's Hospital at Amsterdam** desires, and that the images may be done separately or with my name or name(s) of my minor child(ren) included in the release.

I understand that the purpose of the use or release of the photographic or video images will be for training or marketing purposes.

The use or release of the images will be made either to the public or within **St. Mary's Hospital at Amsterdam**, or both, including, without limitation, commercial or noncommercial publications and exhibits.

I agree that all pictures, reproductions, plates, negatives and tapes of any kind relating to the images are and shall remain the property of **St. Mary's Hospital at Amsterdam** and/or any company to whom permission has been granted, as listed above.

I understand that this Authorization for Photo Release can be revoked by me at any time by submitting a written request to: **St. Mary's Public Relations Department, 427 Guy Park Ave, Amsterdam, NY 12010**.

I understand that revocation will not apply in those instances in which **St. Mary's Hospital at Amsterdam** has acted upon this Authorization prior to the revocation being received by **St. Mary's Hospital at Amsterdam**.

I understand that the images released pursuant to this Authorization may be subject to redisclosure and no longer protected by the laws applying to medical information disclosures.

I understand that **St. Mary's Hospital at Amsterdam** cannot require me to sign this Authorization as a condition for providing me treatment or obtaining payment for treatment, unless the treatment is related to research.

This Authorization will expire: _____. [Insert date or event of expiration.]

[This paragraph applies only if initialed.]

_____ I understand that this Authorization permits **St. Mary's Hospital at Amsterdam** to allow commercial media personnel (TV, newspaper, magazines, etc.) to take photographs, videotape, or other such reproduction for their use.

Signature:	Date Signed:
Signature of Authorized Representative:	Relationship:

A copy of this Authorization must be presented to the person signing the Authorization.