North Memorial
Medical Center
3300 OAKDALE AVENUE NO.
ROBBINSDALE, MN 55422-9988

INFANT PHOTOGRAPHIC RELEASE

Mother's full name (print clearly): ______________________________

Father's full name (print clearly): ______________________________

North Memorial has contracted with a photography company to provide you with photography services. This form allows you to either grant permission to the company to take your baby's photograph, or refuse to grant that permission. This is not an order form, and does not obligate you to purchase photographs.

☐ **I grant permission for my/our child or children to be photographed.**

I understand that the photography company may offer me the option of posting photographs on the company's Web site. If I decide to use the Web site option, I understand that the company will ask me to sign a separate consent for that purpose. I also understand that North Memorial is not affiliated with the photography company's Web site, and that any questions or problems I have with the Web site will be handled by the photography company.

☐ **I do not want my/our child photographed.**

By signing below, I release North Memorial, it's staff, officers, trustees, employees, and agents from any and all claims or liabilities that may arise out of or relate to the taking of photograph(s) in accordance with this consent form.

Date: ____________ Signature: ______________________________ Phone: ____________________

Witness Signature: ______________________________ Department (check one): 4SW 3 West NICU

Baby's first and middle name (print)	Date of Birth

File this form in the patient's medical record.