

Authorization for Release of Information

to be provided to the

Now I Lay Me Down To Sleep Foundation's Affiliated Photographers and Volunteers

My signature below authorizes _____ Hospital to pass my name and limited event information to the Now I Lay Me Down To Sleep organization so that a request can be made for a volunteer to take my baby's photo by a professional photographer. I understand this is a free service performed by professionals volunteering their time and talents to families in need.

Mother's Signature

Date

Room #

Mother's Printed Name

Baby's Printed Name

Mother Admission Date

I understand that the Now I Lay Me Down To Sleep organization is a non-profit organization and the hospital will not receive financial or in-kind compensation in exchange for using or disclosing the information.

I also understand that my treatment at this hospital will not be based on my decision to request photographs. I understand that this is a free gift from the photographer and after he or she provides me with the full copyright released high resolution images on disc, it will be up to me financially to print out whichever images I so choose to purchase at whatever printing lab I so choose.

I understand that my authorization of information may be subject to re-disclosure and may no longer be protected by New Zealand privacy laws.

I understand that I may revoke this authorization at any time prior to information being shared with the Now I Lay Me Down To Sleep organization simply by notifying this hospital in writing.

This authorization shall become invalid and expire 180 days from the date of the signature unless otherwise stated.

I understand that I may request a copy of this authorization after I sign it.

(Hospital Staff: Please place signed form with patient's chart and send to Medical Records at discharge)

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