nilmdts™
Now I Lay Me Down to Sleep

PARENT CONSENT, AUTHORIZATION AND RELEASE FORM

Retouching Request

Please write clearly.

Hospital Name ____

Hospital Contact Name ______________________________________

Hospital Contact Number _____________________________________

Full Name of Child(ren) _____________________________________

Child(ren) Date of Delivery ___________________________________

Parent(s) Full Name(s) ______________________________________

Home Address ____

City _________________State/Prov__________Postal Code ___________

Phone Home (____)_____________Cell (____)______________________

E-mail ____

Images will be delivered via a secured email system.

Parent and/or Authorized Signature ___________________________

Printed Name ____

Images will not be retouched and released until a parent or next of kin is able to provide authorization.

Optional: ☐ Yes, please add my name to the NILMDTS Parent's e-newsletter.

Optional: ☐ Asian / Pacific Islander ☐ Black / African American
☐ Latino / Hispanic ☐ Native American / First Nations
☐ Caucasian ☐ Other

I have contacted Now I Lay Me Down to Sleep (NILMDTS), a nonprofit organization, to request retouching of our images not taken by a NILMDTS volunteer photographer. I understand this will be a gift from NILMDTS and will accept it as such. I agree to, or represent, the following **(initials on all points are *required*, except those marked optional)*:***

1. ***Authorization to Retouch Photographs.*** I am the parent and legal guardian of my child(ren) listed, have the authority to enter into this agreement, and authorize NILMDTS to retouch photographs of my child(ren). **Initial** _____________

2. ***Complimentary Gift***. I understand that NILMDTS provides the free gift of professional quality portraiture as well as retouching services. Images will be professionally retouched and converted to black and white or sepia tones to create an heirloom quality portrait. **Initial** _____________

3. ***Personal Use of Photographs.*** The person taking the photographs holds the copyright to the original images. NILMDTS holds the copyright of edited images which are licensed to parents for personal use. I understand that the images I receive may not be used for commercial use, public media, or promotions of other nonprofits or causes without specific written permission from NILMDTS Headquarters. I agree to contact NILMDTS to obtain permission and information about proper acknowledgment. **Initial** _____________

4. ***Quality of Photographs.*** I understand that not all the photographs submitted can be retouched. NILMDTS will look at the quality of the photo(s) or scan of the photo(s) submitted. It is unlikely a Polaroid or photo not taken with a digital camera can be retouched. **Initial** _____________

5. ***Retouching Guidelines.*** I understand tubes and wires can only be removed under certain circumstances. NILMDTS will not recreate any features of the baby. For example, if tubes cover the baby's lips, the tubes will not be removed because the lips cannot be recreated. NILMDTS will convert to black and white or sepia and will make all attempts to retouch bruising and redness. **Initial** _____________

6. ***File.*** I understand this form or an electronic copy of this form will be maintained by NILMDTS at the headquarters office. **Initial** _____________

7. ***Photographer/NILMDTS Use of Images Permitted.*** I permit the digital images and photographs of my child(ren) to be used by NILMDTS for the NILMDTS volunteer training, hospital education, and agency marketing. For such usage, NILMDTS may make additional copies of the photographs without my prior approval. ***(Optional)*** **Initial** _____________