nilmdts™
Now I Lay Me Down to Sleep

PARENT CONSENT, AUTHORIZATION AND RELEASE FORM

☐ *Affiliated Photography* ☐ *Retouching* ☐ *Medical Affiliates*

Facility Name _____

Facility Contact Name & Number _____

Session Date _____ **Time** _____

Child(ren) First Name _____ **Last Name** _____

Child(ren) Date of Delivery _____ **Gestation Age** _____

Sex: _____ (*optional*) **Ethnicity**: (*optional*) ☐ Asian / Pacific Islander ☐ Black / African American ☐ Latino / Hispanic ☐ White ☐ Other ☐ Native American / First Nations / Indigenous

Parent 1: Full Name _____

Phone (____) _____

Parent 2: Full Name _____

Phone (____) _____

Home Address _____

City _____ **State/Prov**_____ **Postal Code** _____

Images will be delivered via a secured email system.

Parent 1: E-mail _____

Optional: ☐ Yes, please send me the NILMDTS parent communications.

Parent 2: E-mail _____

Optional: ☐ Yes, please send me the NILMDTS parent communications.

NILMDTS Affiliated Photographer or Medical Affiliate Contact Information

Printed Name _____

Phone _____

Email _____

I have contacted Now I Lay Me Down to Sleep (NILMDTS) to request a volunteer photographer or Medical Affiliate who can provide portraits of my child(ren) or I am requesting retouching of our images not taken by NILMDTS. I understand this will be a gift from NILMDTS and will accept it as such. I agree to, or represent, the following (unless marked Optional), initials are required on all points:

1. ***Hospital***. I understand that if a NILMDTS Affiliated Photographer is taking photos, that they are not affiliated with the Facility. ***(Affiliated Photography Only)*** **Initial** _____

2. ***Authorization to Photograph or Retouch Photographs.*** I am the parent and legal guardian of my child(ren) listed, have the authority to enter into this agreement, and authorize the Affiliated Photographer or Medical Affiliate to photograph my child(ren) *or* authorize NILMDTS to retouch photographs of my child(ren), whichever is applicable. *Alternately*, due to the parents' inability to authorize at the time of the session, I have the authority to enter into this agreement on their behalf. **Initial** _____

3. ***Personal Use of Photographs.*** NILMDTS holds the copyright of images taken (Affiliated Photography) or of the edited product (Medical Affiliates and Retouching), and in both cases 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. ***Standard Gift.*** I understand that NILMDTS provides the free gift of professional quality portraiture as well as retouching services. Digital images will be professionally retouched in black and white or sepia to create an heirloom quality portrait. I understand I will receive a digital set of images within 6-8 weeks for Affiliated Photography or 6-12 weeks for retouching and Medical Affiliates, which will allow me to have the photographs printed, at my own cost, by any photo lab. NILMDTS will not provide the originals, non-retouched, or color images per agency policies and guidelines. I understand that I am encouraged to take my own photos during and after the session. **Initial** _____

5. ***Release.*** I release and forever discharge NILMDTS, the photographer, the hospital and their agents, employees, officers, directors, and representatives from all past, present, and future legal claims, actions, causes of action, damages, costs, and expenses that in any way grow out of, or are related to, the taking of photographs and their use of photographs and their use by NILMDTS or the Affiliated Photographer. **Initial** _____

6. ***Indemnification.*** If any person not signing this form brings a claim against NILMDTS or the photographer that is related to the photography of my child(ren), the released matters set forth above, or the use the photographs thereafter, I will indemnify and save and hold NILMDTS and the photographer harmless from any damages incurred as a result of those claims. **Initial** _____

7. ***Electronic Transmission of Data.*** By signing this release, you authorize the NILMDTS Medical Affiliate, medical provider, and/or facility to electronically transmit photographs and this consent form, which may, intentionally or unintentionally, include protected health information and other data related to the individuals named on this consent form. **Initial** _____

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

Authorized Signature _____

Images will not be retouched and released without an authorized signature.

Printed Name _____ **Relationship** _____