

**Information & Photographic  
Authorization/Release**

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the making of photographs, videotape, and/or motion pictures (hereinafter "pictures) of: \_\_\_\_\_

\_\_\_\_\_ by the staff, employees or agents of the Johns Hopkins University School of Medicine and The Johns Hopkins Hospital (hereinafter "the University"), Johns Hopkins Medical Video/Digital Media Group.

I authorize the use of such pictures for the following purpose(s):

- \_\_\_ Educational Purposes
- \_\_\_ Medical Records
- \_\_\_ Media Release
- \_\_\_ Research
- \_\_\_ Publicity
- \_\_\_ Other \_\_\_\_\_

I understand that my name \_\_\_\_\_ will \_\_\_\_\_ will not be included in the credits and that my head and face \_\_\_\_\_ will \_\_\_\_\_ will not appear in the pictures. I understand that the pictures are the property of the University and I relinquish any rights that I may have to the pictures.

I hereby release from liability the University, it's parent, affiliates and subsidiaries, as well as the staff, agents, and employees of such entities for their acts or omissions performed in connection with the making and use of these pictures or with the release of these pictures.

SIGNED: \_\_\_\_\_ DATE \_\_\_\_\_

WITNESSED: \_\_\_\_\_ DATE \_\_\_\_\_

PROJECT: \_\_\_\_\_