1. I, ___________________________________________________________, am a parent or legal guardian of
_________________________________________________, a minor child. By signing below, my minor child
and I agree to participate in an interview and the allow use of the information obtained for the following purpose:

___________________________________________________________________________________________

___________________________________________________________________________________________

2. I, ____________________________________________________________, am a parent or legal
guardian of _______________________________________________, a minor child. By signing
below, my minor child and I are authorizing the Virginia Commonwealth University Health System
(VCUHS) to use photographic, digital or video images of my minor child for the following specific
purpose:___________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

3. VCUHS has explained to us that the photographic, digital or video images of my child will only be used for the
purpose stated above. We understand that neither I, nor my child, will receive compensation in exchange for the
use of the photographic, digital or video images.

4. I have had the opportunity to ask questions about the purpose for which, and about the manner in which, the
photographic, digital or video images will be used, and all my questions have been answered satisfactorily. I
hereby release and hold harmless VCUHS, the Medical College of Virginia Hospitals and Physicians, and their
respective officers, employees and agents from liability for any claim I have, or might ever have, in connection
with the use of the photographic, digital or video images.

5. I understand that I may refuse to sign this Authorization. If I choose not to sign, my child’s treatment will not
be affected in any way.

6. I understand that information used or disclosed under this Authorization might be re-disclosed by a recipient
and may, as a result, no longer be protected to the same extent it is protected while in the possession of VCUHS.

7. This Authorization is subject to revocation in writing at any time except to the extent that VCUHS has already
taken action in reliance on it. I may revoke the Authorization by written notification to the following
__________________________________ at VCUHS.

(Person Obtaining Authorization)

If not previously revoked, this Authorization will terminate upon: _____________________________________

(specific date, event or condition)

Signature of Child (if over 13 years of age) Date

Signature of Parent or Legal Representative Date

Person Obtaining Authorization Signature Printed Name/ Title Date Time

Witness Signature Printed Name/ Title Date Time