The Johns Hopkins Hospital / Johns Hopkins University School of Medicine

Information & Photographic Authorization/Release

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

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___ 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.

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WITNESSED: _____ DATE_____

PROJECT: _____

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