

AUTHORIZATION TO BE PHOTOGRAPHED, RECORDED AND/OR INTERVIEWED
(Authorization for Use of Photographs, Recordings, and/or Interview Material)

Name of Participant or Patient: _____
Address: _____
Phone #: _____

I hereby voluntarily authorize the International Rett Syndrome Foundation dba Rettsyndrome.org and/or their subsidiaries, affiliates, agents, contractors, providers or employees to interview, record and/or take photographs of myself, minor child, or individuals of whom I have guardianship. I also give them permission to use photos I have submitted to the organization for the purposes expressed below. I understand that the term photograph may include, but not be limited to, videotape, videodisc, digital image and any other mechanical means of recording or producing visual images (hereinafter referred to as "photographs"). I also understand the interview session may involve, but not be limited to, audio tape, or other recording device, written recording or other mechanical means or medium to preserve the discussions (hereinafter referred to as "interview material").

I understand and agree that the photographs and/or interview material may also be used and/or disclosed to the public for any and all other purposes deemed appropriate by the International Rett Syndrome Foundation dba Rettsyndrome.org dba as Rettsyndrome.org and/or any subsidiaries, and affiliated organizations of such entities. Such purposes may include, but not be limited to education, treatment, public relations, advertising, communication materials, promotional and marketing publications (including postings on an organization's website), and/or fundraising activities.

I agree to hold harmless the International Rett Syndrome Foundation dba Rettsyndrome.org and/or any subsidiaries, affiliates, agents, officers, contractors, providers, directors and employees, or other third parties designated by these entities or individuals that are involved in the production, duplication, publication or other use and/or disclosure of the photographs, and/or interview material for any damages or losses incurred by such use and/or disclosure of the photographs and/or interview material. I also understand that the photographs and/or interview material used and/or disclosed pursuant to this authorization may be re-disclosed by a recipient and such cannot be controlled by any of the aforementioned parties.

In addition, I waive all rights to or conditions on the use and/or disclosure of these photographs and/or interview material that I may have pursuant to this authorization and waive any claim for payment or royalties related to the production, duplication, publication or other use and/or disclosure of the photographs or interview material by the International Rett Syndrome Foundation dba Rettsyndrome.org, and/or any subsidiary or affiliate, or any other party involved in any use and/or disclosure now or in the future.

Expiration. This authorization will expire when no further production, duplication, publication or reprint or any other use of the photographs or interview material is required by the International Rett Syndrome Foundation dba Rettsyndrome.org and/or their subsidiaries or affiliates.

Revised Dec 2019 TF

Name: _____

(Please print name of participant or patient)

Signature: _____

Date: _____

If the participant involved is under 18 or unable to grant authorization, his/her parent or legal guardian must provide authorization;

I hereby certify that I am the parent or legal guardian of _____, named above. I do give my authorization without reservation to the foregoing.

Name of Participant's parent or legal guardian: _____
(Please print name of parent or legal guardian)

Signature: _____

Date: _____