PHOTOGRAPH RELEASE FORM

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Developmental Medicine

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I hereby release and hold harmless the AACPDM and Sponsor from any reasonable expectation of privacy or confidentiality for myself and for the minor child(ren) listed below associated with the images submitted. Further, I attest that I am the parent or legal guardian of the child(ren) listed below and that I have full authority to consent and authorize the AACPDM to use their likenesses and names.

I further acknowledge that participation is voluntary and that neither I nor the minor child(ren) will receive financial compensation of any type associated with the taking or publication of these photographs or participation in AACPDM or Sponsor marketing materials or other AACPDM or Sponsor publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

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Names and Ages of Minor Children:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Signature: _____ Date: _____

Please return this completed form to the AACPDM:
AACPDM - 2019 LifeShots Photo Contest
555 E. Wells Street, Suite 1100
Milwaukee, WI 53202
meetings@aacpdm.org or Fax: 414-276-2146