



**CONSENT TO PHOTOGRAPH
INFANT - NEBRASKA**

Patient Label

Consent to Photograph Infant- Nebraska

I, the undersigned, do hereby authorize Banner Health Ogallala Community Hospital and the attending physician or other persons, to photograph my child while under the care of Ogallala Community Hospital, and agree that they may use or permit other persons to use the negatives or prints prepared for such purposes and in such manner as may be deemed necessary

Mother's Signature _____ Date _____

Father's Signature _____ Date _____

Witness Signature _____ Date _____

Baby Photography Release

I hereby give my permission to have my child's photograph appear in the Ogallala Community Hospital Family Album in the Keith County News.

I do not give my permission to have my child's photograph appear in the Ogallala Community Hospital Family Album in the Keith County News.

Mother's Signature _____ Date _____

Father's Signature _____ Date _____

Witness Signature _____ Date _____

