Babysitting Class Registration Form

Participant Name: ____

Participant DOB: _____________ Phone Number: __________________

Participant Address: ____

Photo and Information Release Form

I give my permission to Ripon Medical Center (RMC) and the Foundation for Ripon Medical Center (FRMC) to use my photographic image and/or comments for public interest purposes, such as, but not limited to; news releases, brochures, news stories, the RMC and FRMC website and in other similar contexts to promote RMC, FRMC and the programs we support.

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Participant Last Name First Name Phone #

____

Street Address City State Zip Code

Additional Comments:

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***This authorization will remain in effect unless I contact the Marketing Coordinator of Ripon Medical Center. I understand that this withdrawal will not affect information already used or disclosed pursuant to this authorization.**

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: *Right to inspect and copy the information to be used or disclosed* – I understand that I have the right to inspect or copy the information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my information or obtain copies of my information by contacting the Marketing Department. I am also aware that there may be a cost involved to receiving copies of my information. *Right to receive copy of this authorization* – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. *Right to refuse to sign this authorization* – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. *Right to withdraw this authorization* – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Marketing Department.

____ ____________________

Signature of Parent or Legal Guardian Date

Please return this form with payment of $35 (cash or check) to:
Ripon Medical Center
Attn: Community Outreach Coordinator
933 Newbury St., Ripon, WI 54971