INTERNATIONAL CENTER FOR SPINAL CORD INJURY
AT KENNEDY KRIEGER INSTITUTE

15th Anniversary Patient Yearbook

The International Center for Spinal Cord Injury is turning fifteen years old!

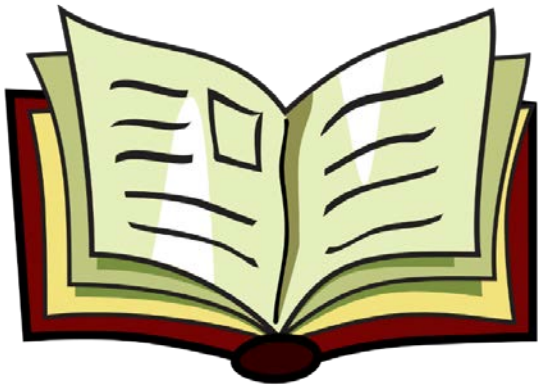
To celebrate *15 Years of Hope*, we are encouraging current and former patients and their families to share their own stories as a part of an ICSCI Yearbook.

If you would like to participate, please send your submission to **ICSCInews@kennedykrieger.org** by **January 12, 2019**.

Submissions should include:

1. A yearbook entry.
2. At least one high-resolution picture.
3. A signed copy of the Marketing Consent form.

Copies will be printed and shared at our 15th anniversary celebration.



Our anniversary celebration will be held March 7-13, 2020! We have an exciting week of events planned. More details to come.

If you would like to be added to our email updates list, please send an email to: ICSCInews@kennedykrieger.org

Please send questions and submissions to **ICSCInews@kennedykrieger.org**.

ICSCI YEARBOOK SUBMISSION GUIDE

All submission styles are welcome, the below questions are included as a guide. Share as much or as little as you would like about your experiences.

Please be sure to include your (1) name, (2) hometown/state, (3) the date of your injury or diagnosis, and (4) age.

Sample questions:

1. Why did you come to Kennedy Krieger?
2. What changes have you seen since you came to Kennedy Krieger?
3. Tell us about your experience at Kennedy Krieger.
4. What has been the hardest part about your therapy at Kennedy Krieger?
5. What is the best part about your therapy at Kennedy Krieger?
6. What can you do now, that you did not imagine you could do, prior to coming to Kennedy Krieger?
7. What are your future goals?

There is no word count limit to entries, although final versions may be edited for spacing.

Please submit to ICSCInews@kennedykrieger.org by January 12th.

Kennedy Krieger Institute

Check appropriate box below:

☐ **Patient**

☐ **Nonpatient**

You may revoke this authorization by 1.) emailing your request, with a copy of the original authorization attached to your email, to **Marketing@KennedyKrieger.org** or by 2.) mailing a written request, along with a copy of the original authorization, to **Kennedy Krieger Institute, External Relations, 707 N. Broadway, Baltimore, MD 21205**.

If you are unable to provide a copy of the original authorization with your request to revoke, you must provide the patient's name and date of birth. If you are unable to provide all of the above information, Kennedy Krieger may not be able to honor the revocation request.

AUTHORIZATION FOR USE OF INFORMATION AND IMAGES FOR MARKETING COMMUNICATIONS

Kennedy Krieger Institute is grateful to individuals (e.g., patients, families and community members) willing to participate in promoting the Institute by sharing or participating in photos, stories and experiences related to the Institute. The Institute's staff pledges to maintain strict patient confidentiality in keeping with high ethical standards and in accordance with state and federal laws. We require your written permission to use your (or your child's) personal information and/or likeness. Please see below. Thank you.

☐ **I give permission for Kennedy Krieger Institute to create, share or disclose my (or my child's) photographs, video or audio recording, images and basic identifying information, as well as information about my (or my child's) treatment and/or experiences related to the Institute in communications. Communications may include, but are not limited to, brochures, advertisements, webpages or social media sites (e.g., Facebook, Twitter, Instagram, YouTube and similar sites) and news media (e.g., TV, radio, newspapers and magazines).**

I understand I may withdraw this permission at any time for the FUTURE USE or disclosure of my (or my child's) information, photographs and images by following the guidelines at the top of this form. However, I understand this withdrawal would ONLY affect the FUTURE use and disclosure of my (or my child's) information, photographs and images that have not been previously published. I understand this revocation does NOT apply to the future publication, broadcasting, etc. of my (or my child's) information, photographs or images by media that have previously published, broadcast, etc. the information, photographs or images. Once my (or my child's) information has been disclosed, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person or entity who received it. If I authorize any of the uses above, I hereby release and waive all claims to compensation and rights regarding such uses and publication. I am not required to sign this authorization. If I choose not to sign, the Institute will not disclose my (or my child's) information as noted above, and my (or my child's) treatment will not be impacted.

PLEASE PRINT LEGIBLY AND CHECK ONE: Completing form on behalf of ☐ self or ☐ someone else.

Individual's full name_____ **Gender**_____

Individual's signature_____ **Date**_____ **Time**_____

Address_____**City**_____

State, Zip_____ **Cell phone**_____ **Email**_____

Date of birth_____/ _____/_____ **Age**_____ **Diagnosis (if a patient)**_____

IF YOU ARE NOT THE INDIVIDUAL ABOVE, BUT ARE SIGNING ON BEHALF OF THE INDIVIDUAL, COMPLETE THE FOLLOWING:

Representative's name_____ **Relationship to individual**_____

Representative's signature_____ **Cell phone**_____

Address_____ **State, Zip**_____ **Email**_____

If you are a healthcare agent or guardian, please attach proof of your authority to act on behalf of the patient.

INTERNAL USE ONLY

Medical record #:_____ Institute project:_____

Staff member obtaining consent (full name):_____

Institute department/clinic/program:_____

Notes:_____

Please make sure names are clearly printed. If not, please rewrite names so they are legible.