**Authorization for reproduction of a photographic image, audio and/or video**

I [signatory’s name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, identified with ID document \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ issued by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, in representation of [child’s name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the Pan American Health Organization/World Health Organization (PAHO/WHO) to reproduce the image, portrait, and/or voice of [child’s name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, whether recorded on audio, video, and/or in a photograph.

I acknowledge that this Authorization does not involve any payment or remuneration, including royalties or any other compensation resulting from the use of said image, portrait, and/or voice, or related thereto.

I am aware that the image, portrait, and/or voice of [child’s name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ may be edited, copied, exhibited, published, or distributed, without my having the right to examine or authorize the reproduction of the final product in which said image, portrait, and/or voice appears.

I understand that by signing this Authorization, I am allowing these photographs and/or video recordings in which the image and/or voice of [child’s name] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ appear to be disseminated and/or reproduced by different means, including electronically.

This Authorization does not have an expiration date, nor is it restricted to any geographical scope whatsoever regarding the distribution and/or reproduction of these materials.

By signing this Authorization, I acknowledge that I have read in its entirety and fully understood its contents, and, aware of its legal repercussions, agree to abide by them.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_