



American Porphyria Foundation
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MEMBER CONSENT FORM

I, _____, hereby authorize and consent to the publication of my name, member story and photograph(s) provided by me. This information can be used on the American Porphyria Foundation (APF) website, the APF newsletter, and and/or in the “Member Stories” section of the APF website. I voluntarily make this authorization and consent to this publication, fully realizing that I may be contacted directly by others as a result of this listing, and that the APF has no control over the subsequent distribution and use of information so published.

This permission shall continue in effect until such time as it is revoked in writing by me.

I am at least eighteen years of age. **YES**____ **NO**_____

I am the parent/guardian of: Child’s full name: _____

Signature: _____

Date: _____

Name (please print): _____

Address: _____

Telephone: _____

E-mail: _____