

SAINT VINCENT HEALTH CENTER
232 West 25 Street
Erie, Pennsylvania 16544
814/452-5000



Newborn Photo Request

Date _____

Patient name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Mother's date of birth: _____ Baby's date of birth: _____

male female

5-digit Cherished Memories photo identification number: _____

How would you like to receive your baby's photo? (Please select one):

Mail E-mail E-mail address: _____

RECEIPT AND ACKNOWLEDGMENT

I, _____, acknowledge that I will receive from Saint Vincent Health Center, a photo of my child, born at Saint Vincent and taken as part of an offer made to me by independent contractor "Cherished Memories" located in Aliquippa, PA. I also acknowledge that, despite Saint Vincent's delivery of my child's photo, Saint Vincent has no legal obligation or responsibility to fulfill or satisfy any offers, promises, guarantees, or liabilities of "Cherished Memories".

Signature _____

If you do not have an e-mail account you can print this form and mail it back to us at the following address:

Saint Vincent Health Center, Patient Relations
232 West 25 Street
Erie, PA 16544

If you have additional questions please call Saint Vincent patient relations at 814-452-7081.