MemorialCare

CONSENT TO PHOTOGRAPH, AND AUTHORIZATION TO PUBLISH INFORMATION, STATEMENTS, PHOTOGRAPHS OR IMAGES

Name: _____

CONSENT AND AUTHORIZATION:

I give my consent to Memorial Health Services and its subsidiaries, affiliates, officers, personnel, and agents (collectively "MHS"), to interview and/or photograph me. The term "photograph" refers to motion picture or still photography in any format, as well as videotape, videodisc and any other mechanical means of recording and reproducing images.

I agree and understand that the photographs and/or publication of information about me may reveal the fact that I am/was a patient, employee, or contractor of MHS, and may contain other information about me, including patient identifying information.

I authorize the use or disclosure of my statement(s) and/or photograph(s) for any purpose, including but not limited to dissemination to staff, physicians, other healthcare professionals and members of the public for educational, treatment, research, scientific, marketing, public relations, promotional and charitable purposes, and that such dissemination may be accomplished in any manner, and that such use is subject only to the following limitations:

I hereby waive any right to compensation for such uses, and I and my successors or assigns hereby hold MHS, my physician(s), and any other person participating in my care harmless from and against any claim for any injury, and any compensation, resulting from the activities authorized by this consent.

I understand that this Authorization is effective until I revoke it by notifying MHS.

MY RIGHTS:

- I may refuse to sign this Authorization, and such refusal will not affect my treatment, payment, enrollment, eligibility for benefits, contract or employment.
- I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the HR department at my campus (for employees) or the medical records department of the campus where I was treated (for patients). I understand that if my revocation is received after I have given my permission to use and disclose the photograph(s), MHS will not permit further release of any photograph, but will not be able to call back any photographs or information already released.
- I have a right to receive a copy of this Authorization.
- I understand that I will not receive any financial compensation.
- MHS will not receive compensation for the use or disclosure of my photograph(s) unless otherwise indicated here: _____

By signing below, I agree to the terms of this Authorization.

_____ _____

SIGNATURE PRINT NAME

☐AM ☐PM

_____ _____ _____ _____

DATE OF BIRTH EMPLOYEE ID (IF APPLICABLE) TODAY'S DATE TIME

_____ _____

IF SIGNED BY SOMEONE OTHER THAN THE PATIENT, INDICATE RELATIONSHIP WITNESS

This Authorization should be filed in the patient's medical record