Sacred Heart Health System

CONSENT / AUTHORIZATION FOR PHOTO OR INTERVIEW

Name:		**Address:** Street: _____ City: _____ State: _____ Zip: _____
Telephone Number:	**Birth Date:**	

I hereby authorize Sacred Heart Health System, it associates and its parent company **(Ascension Health)** or representatives of the news media to photograph, copyright, use and publish my photographic or video image or the photographic or video image of me or **my minor child(ren):** _____

(Name of child or children)

I understand that the photographic or video image may be produced and released in any form, in whole or in part, with such alterations and changes as Sacred Heart Health System desires, and that the images may be done separately or with my name or name(s) of my minor child(ren) included in the release.

I understand that the purpose of the use or release of the photographic or video images will be for training, public relations or marketing purposes or for purposes of a news story.

I also authorize an interview of me or my minor child for the purposes of public relations, news articles, broadcasts, fund-raising, or education.

The use or release of the images will be made either to the public or within Sacred Heart Health System, or both, including, without limitation, commercial or noncommercial publications and exhibits.

I agree that all pictures, reproductions, plates, negatives and tapes of any kind relating to the images are and shall remain the property of **Sacred Heart Health System** and/or any company to whom permission has been granted, as listed above.

I understand that this Authorization for Photo Release can be revoked by me at any time by submitting a written request to:

Public Relations Manager, Sacred Heart Marketing, 5151 N. Ninth Avenue, Pensacola, FL 32504

I understand that revocation will not apply in those instances in which Sacred Heart Health System has acted upon this Authorization prior to the revocation being received by **Sacred Heart Health System.**

I understand that this Authorization permits Sacred Heart and **Ascension Health** to allow commercial media personnel (TV, newspaper, magazines, etc.) to take photographs, videotape, or other such reproduction for their use.

I understand that the images released pursuant to this Authorization may be subject to redisclosure and no longer protected by the laws applying to medical information disclosures.

I understand that **Sacred Heart Health System** cannot require me to sign this Authorization as a condition for providing me treatment or obtaining payment for treatment, unless the treatment is related to research.

This Authorization will expire: 2099

Signature:	**Date Signed:**
Signature of Authorized Representative:	**Relationship:**

A copy of this Authorization must be presented to the person signing the Authorization.

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