Chan Soon-Shiong Medical Center at Windber

Communications/Marketing Department
600 Somerset Avenue
Windber, PA 15963
814-467-3447

MEDIA AUTHORIZATION

Please read the information below carefully before signing this form. *PLEASE DO NOT SIGN A BLANK FORM.*

I, (print name) _____, hereby grant Chan Soon-Shiong Medical Center at Windber (further referred to as CSSMCW) the rights of my and/or my child's (if applicable) image, in video or still, and the likeness and sound of my and/or his/her voice as recorded on audio or video for use in any publication, film, public relations, marketing, advertising, fundraising, or other purposes that CSSMCW may desire. I also give full permission to the following photographer/videographer (if applicable) _____ to photograph, record video, and/or audio for the purpose of the marketing and promotion of the covered entities to the general public.

I understand that said image or recording may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product wherein said likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of said image or recording. I also understand that this material may be used in diverse settings within an unrestricted geographic area. Once released to the media or published online, the hospital cannot control further distribution, sharing, copying, or archiving of this content. Digital content may be publicly accessible indefinitely, even if later deleted from hospital platforms.

I understand and agree that such documentation may be retained by CSSMCW in its library, files, and/or its website, and thus may be subject to continuing use and disclosure for the purposes described herein until I revoke this consent form.

I release CSSMCW, its employees, and consultants from any claim or liability relating to the use of my and/or my child's (if applicable) name, image, and/or recording and any accompanying disclosures.

If you are a <u>parent/legal guardian of a non-patient</u>, please list participating minor's name/s in this box:

_____

If you are a <u>patient</u> or a <u>parent/legal guardian of a patient</u>, please fill out the information in this box:

SPECIFIC UNDERSTANDINGS: Information about you and your health is personal, and we are committed to protecting the privacy of that information. We must obtain your written authorization before using or disclosing your protected health information for the purposes described on this document. By signing this authorization form, you authorize use or disclosure of your protected health information described on this document. You have the right to refuse to sign this authorization. Your health care treatment, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

_____ (initial) **As a patient**, I hereby grant CSSMCW and any entity listed above authorization to disclose my health information needed for this project, including but not limited to diagnosis and treatment, to educate the general public about a positive patient experience at CSSMCW for use in any publication, film, public relations, marketing, advertising, fundraising, websites, social media platforms, digital advertising, podcasts, streaming media, electronic publications, and future communication technologies or other purposes that CSSMCW may desire.

_____ (initial) **As a parent/legal guardian of a patient**, I hereby grant CSSMCW and any entity listed above authorization to disclose my child's (print minor's name/s) _____ health information as needed for this project, including but not limited to diagnosis and treatment, to educate the general public about a positive patient experience at CSSMCW for use in any publication, film, public relations, marketing, advertising, fundraising, websites, social media platforms, digital advertising, podcasts, streaming media, electronic publications, and future communication technologies or other purposes that CSSMCW may desire.

The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. You have the right to receive a copy of this form after you have signed it. You have the right to revoke this authorization at any time. Please write to Communications/Marketing at Chan Soon-Shiong Medical Center at Windber to revoke this authorization.

Full Name: _____ **[ ] I acknowledge that I am at least 18 years of age.**

Home Address, City, State, Zip: _____

Home/Cell Phone: _____ **Personal Email:** _____

Signature: _____ **Date:** _____

Signature of Witness: _____ Date: _____ Phone: _____