HH HUNTSVILLE HOSPITAL

Consent to Photograph

Marketing & Public Relations

Authorization for Filming or Recording Release Form

I authorize the release of the initialed item below to be disclosed in the manner described:

____ I agree to grant an interview with, and/or to be photographed, videotaped, or recorded by a **representative of print or broadcast media**, and I understand that my information, image and/or voice may appear in print or broadcast media.

X I agree to grant an interview with, and/or to be photographed, videotaped, or recorded **representative of Huntsville Hospital** and I understand that my information, image and/or voice may appear in Huntsville Hospital promotional or educational material (advertisement, publication, video, web site, etc.).

____ I agree to grant an interview and/or to be photographed, videotaped, recorded by a representative of **law enforcement, public health or social service agency**.

X I understand that I (will, will not) be identified by name and that protected health information (will, will not) be shared with the person performing filming or recording.

The purpose for the use/disclosure of this information is:

☐ Cooperation with request from media ☐ Education of health care professionals ☒ Hospital publicity or public education

☐ Investigation of a possible crime ☐ Other____________________

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Huntsville Hospital Marketing Department. I understand that revocation will not apply to information that has already been released in response to this authorization.
I also understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

X____________________ ____________________
PRINT NAME Day Time Phone Number

X____________________ ____________________
Signature (or Legal Representative) of individual being photographed, etc. Legal Representative's Relationship to Patient

____________________ ____________________
Physical Description of Consenter Witness

X____________ ____________ ____________
Date Department (*If HH Employee*) Employee ID# (*If HH Employee*)

Identification of Personal Representative if the patient is unable to authorize:
__Driver's License __Work photo badge __ Other photo ID __Power of attorney documentation

The original of this document is to be placed in the patient's medical chart and a copy to be maintained in Marketing & Public Relations (Fax 265-8921)

PHOTOGRAPHED EVENT:

DATE: