AUTHORIZATION FOR USE OF MEDICAL INFORMATION FOR MEMORIAL HEALTHCARE SYSTEM PUBLICATION

PLEASE READ THIS FORM CAREFULLY AND COMPLETELY BEFORE SIGNING

Memorial Healthcare System ("MHS") is always grateful when patients, families, and friends are willing to share their stories about their experience with us. Your story helps others who are seeking information about the interactions, care, and treatment that MHS provides.

At MHS, patient privacy is one of our highest priorities, and we maintatin this privacy by ensuring that your and/or your child's health information is kept confidential. MHS is seeking your permission to use your and/or your child's health information and to take and use audio/video/photographic material of you and/or your child in MHS's internal and external communications, including use for medical education, public affairs, fundraising, and marketing activities. Such materials may be used in publications that are in the form of: print, online, or media (such as TV, radio, newspapers, magazines, and social media).

Patient Information:

Name: _____ Date of Birth: _____

Address/City/State/Zip: _____

_____

Primary Phone #: _____ Secondary Phone #: _____

I, _____, hereby represent that I am the patient OR I am the parent or legal guardian of the
Name
above-referenced patient (herein referred to throughout as "my child"), and I agree and give my permission and consent for MHS to film, videotape, photograph, and/or interview, me and/or my child. I give permission to MHS to copyright, use and reuse these materials and reproductions and simulations of me and/or my child's likeness in any publication format.

I understand that, by agreeing to this Authorization, my or my child's health information that is disclosed may no longer be protected by state and federal privacy laws.

I understand that I am not required to sign this Authorization and that MHS does not condition my or my child's treatment, payment, benefit eligibility or enrollment activities on the signing of this form, and I will not be entitled to any payment, royalties, or any other forms of compensation as a result of the use of any information.

I hereby release and discharge MHS from any and all claims and demands arising out of or in connection with the use of any publication material in accordance with the terms of this Authorization, including but not limited to any claims for defamation, invasion of privacy, or infringement of copyrights or moral rights.

I understand that photographs, electronic images, films, and/or video/audio tapes may be edited, modified, or retouched for artistic purposes or for other graphic production reasons, which may or may not be within MHS's control, and I waive any right to inspect or approve the finished publication. I understand and authorize MHS's medical staff, employees, and agents who rendered care to me or my child to discuss my or my child's care, diagnosis, and treatment.

I understand and agree that this Authorization is valid for present and future publications and has no expiration date. I understand that I may revoke or withdraw this permission up until a reasonable time before the publication material is used by providing my revocation of this Authorization in writing to MHS Marketing and Corporate Communications Department.

LEGAL DEPARTMENT
Stirling Road, Hollywood, FL 33312 Tel. (954) 265-5933 Fax (954) 276-0487 MHS.net
South Broward Hospital District

3111 Stirling Road, Hollywood, Florida 33312. I understand that any revocation of this Authorization will only apply to the versions of information within MHS's control that have not been previously published.

I have fully read and understood the above Authorization, and I am fully familiar with its contents. I further acknowledge that photocopies of this signed authorization will be honored to the same extent as the original.

By signing below, I acknowledge that I have fully read this form, that all of my questions about this form and the use of my and/or my child's information for publication have been answered, that I have no further questions at this time, and that I accept all of the above.

Individual Signature or Parent/Authorized Legal Representative/Guardian

Date

Printed Name of Individual or Parent/Authorized Legal Representative/Guardian

Legal Representative/Guardian's Relationship to Individual

Minor's Name

Witness Signature

Date

Witness Printed Name

Family Member / Friend Attestation

I, _____, am a family member/friend of the above-referenced patient, and I consent for MHS
Name
to film, videotape, photograph, and/or interview me. I hereby release and discharge MHS from any and all claims and demands arising out of or in connection with the use of the publication material in accordance with the terms of this Authorization, including but not limited to any claims for defamation, invasion of privacy or infringement of copyrights or moral rights. I understand that photographs, electronic images, films, or tapes may be edited, modified, or retouched for artistic purposes or for other graphic production reasons, which may or may not be within MHS's control, and I waive any right to inspect or approve the finished publication. I will not be entitled to any payment, royalties, or any other forms of remuneration as a result of any publication. I understand and agree that this Authorization is valid for present and future publications and has no expiration date. I understand that I may revoke or withdraw this permission up until a reasonable time before the publication material is used by providing in writing my revocation of this Authorization sent to MHS Marketing and Corporate Communications Department, 3111 Stirling Road, Hollywood, Florida 33312. I understand that any revocation of this Authorization will only apply to the version of information within MHS's control which have not been previously published.

Printed Name: _____ Printed Name: _____ Printed Name: _____

Signature: _____ Signature: _____ Signature: _____

Date: _____ Date: _____ Date: _____

LEGAL DEPARTMENT
Stirling Road, Hollywood, FL 33312 Tel. (954) 265-5933 Fax (954) 276-0487 MHS.net
South Broward Hospital District