CHILDREN'S HEALTH

CONSENT
CMC69646-002NS **Rev. 11/2018**

Media Image Authorization and Consent Form

I authorize and consent for Children's Health System of Texas and its affiliates (collectively "Children's Health") to take photographs, videotape, and digital images and to make audio recordings (collectively referred to as "Images") at Children's Health or a Children's Health event of the following individual:

Print First / Last Name: _____ ("Individual") **Date of Birth:** _____

I further authorize Children's Health to use and release such Images to third parties, including but not limited to event sponsors and the general public, through broadcast, print, the Internet, or any other means for the following purposes:

1. Publicity, marketing and fund-raising
2. News releases
3. Educational lectures and presentations
4. Publications such as journals or books
5. Patient educational materials

If Individual is or has been a Children's Health patient, Individual's Images may include protected health information (PHI), and I specifically authorize Children's Health to release and use Individual's Images including PHI. I understand that Individual may be identified by name or other identifying information in connection with the use and release of Images. I understand that once the Images and the PHI associated with the Images have been disclosed, they are no longer protected by state and federal privacy laws and may be subject to redisclosure by third parties. I understand that this authorization is voluntary and I may refuse to sign. Children's Health will not condition Individual's treatment, payment, enrollment or eligibility for benefits on the completion of this authorization.

I agree that this consent to take Images will remain in effect for one year and this authorization to use and release Images, including any PHI associated with Images, will remain in effect until this child reaches the age of 18 (for minors) or for 50 years from the date of this authorization (for adults), unless otherwise revoked in writing. Except to the extent that Children's Health has relied on it, I understand that I may revoke this consent and authorization for the production, use and release of Images at any time by sending a written statement of revocation that specifically refers to this authorization.
The written statement of revocation should be sent to: Children's Health; Attn: Privacy Officer, 1935 Medical District Drive, Dallas, Texas 75235 or email directly to privacy@childrens.com

I release Children's Health and its directors, officers, agents and employees from any and all liability connected with the production, use or release of Individual's Images and any PHI associated with Images. If this release is being signed on behalf of a child under the age of 18, I certify that I am the parent or guardian of the child and that I have the legal authority to sign this release.

By signing this authorization and consent, I acknowledge that I have read and understand the statements contained herein. I understand that Children's Health will provide me with a copy of this signed authorization and consent form upon request.

Signature of Patient / Legally Authorized Representative		Date	Time
Printed Name of Patient / Legally Authorized Representative		Relationship to Patient	
Phone Number		E-Mail Address	
Street Address		City, State, Zip	
Signature of Witness / Interpreter	(circle one): RN LVN APN PA N/A Credentials	Date	Time
Printed Name of Witness / Interpreter		*If telephone translation, name of Interpreter, ID number and Translation Services vendor	
Department obtaining consent			