Authorization for use and release of information and images

Boston Children's Hospital
Where the world comes for answers

➤ Primary patient/individual

First Name:_____ Last Name:_____

Date of Birth:(00/00/0000)_____

➤ Legal guardian

Signature of individual/parent/legal guardian:_____ Date:_____

Please Print Name:_____ Relationship to patient:_____

➤ Family member(s) under guardianship of signer above (if any):

1. Name:_____ Description:_____

2. Name:_____ Description:_____

3. Name:_____ Description:_____

➤ Address and contact information *(required)*:

Address: _____

City: _____ / State:_____ / Zip: _____

Home phone:_____ Mobile: _____

Email:_____

➤ Expiration: This authorization will expire on: Month:_____ Day:_____ Year:_____

Please return this completed form to: Boston Children's Hospital, Marketing and Communications, 300 Longwood Avenue, LM 6168, Boston, MA 02115. If you have any questions about this form or how your information will be used please contact us at 617-919-3110 or marcom@childrens.harvard.edu.

I authorize The Children's Hospital Corporation [d/b/a Boston Children's Hospital] to photograph and record (in broadcast, on film, images, videotape, digital or print media formats, sound recordings, social media, or otherwise) during interviews, celebrations or events, diagnostic and/or treatment sessions, operations and/or other surgical or medical procedures at Boston Children's.

» This authorization pertains and extends to all individuals listed above.

» I authorize the use and release of the above-listed individuals' details of their medical care and demographic information, and such photographs and recordings obtained from situations described above to Boston Children's.

» I am aware that Boston Children's cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Boston Children's may or may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature above.

» I can, however, cancel this authorization in writing at any time except in cases where Boston Children's has already released Information. For example, Boston Children's will not be able to retract a TV segment once it has been aired and will not be able to retract a story, image or video once it has been placed on the Internet. In these cases, I understand that neither Boston Children's nor I can control how and when my image and other information appears. All revocations must be sent in writing to: **Boston Children's Hospital, Marketing and Communications Department, 300 Longwood Avenue - LM 6168, Boston, MA 02115**.

» I authorize Boston Children's to use this information for fundraising and marketing to appear in all media, including print, broadcast, Internet and online. This includes social media networks (e.g. Facebook, YouTube, etc.), to promote, publicize or fundraise for Boston Children's Hospital.

» I understand that the care provided by Boston Children's will not be affected if I do not authorize this release.

For internal use

Boston Children's staff _____ Event or purpose _____

Phone _____ Date of recording _____

Email _____ Location _____

Description of child _____