Authorization for Release of Media Information

This form is a part of our effort to protect your rights. If you have any questions or concerns, please talk to the person helping you with the form.

Originating Entity / Entities

- ☐ Barnes-Jewish Hospital
- ☐ St. Louis Children's Hospital
- ☐ Barnes-Jewish West County Hospital
- ☐ Barnes-Jewish St. Peters Hospital
- ☐ Washington University

I authorize Barnes-Jewish Hospital, St. Louis Children's Hospital, Barnes-Jewish West County Hospital, Barnes-Jewish St. Peters Hospital and/or Washington University to disclose to media representatives and/or public affairs/relations representatives protected health information and information about me, my condition or treatment for purposes of publications, fundraising, advertising, marketing, research/education programs, publicity, promotion, education or publication in print, broadcast and electronic media, including social media. This authorization includes my likeness on photo, videotape and digital media.

Briefly describe nature of project, including a specific description of what health/personal information will be involved and the specific audience or type of audience that may be involved: _____

_____

_____

This authorization also allows the media/public affairs/relations representatives to take photographs, films, audio and/or videotapes, interview me or publish information about me, and to use my likeness and information in an appropriate manner for the above project.

List any limitations to the use of my information, photos, etc. here: _____

_____

_____

For future projects, I authorize the following: (Please choose one)

- ☐ Reuse for future projects (Initial here: _____)
- ☐ Reuse for future projects only with my consent (Initial here: _____)
- ☐ May not reuse for future projects (Initial here: _____)

I consent to the taking and use of the photographs, films, audio and/or videotapes, or other materials as described above. I understand that I may be identified in any use of the above materials. I realize that I will not be compensated in any way for the taking or use of photographs, films, audio and/or videotapes, or the publishing thereof. I understand and agree that this Authorization is valid for 10 years unless I cancel it in writing (as described in the next sentence). I understand that I may cancel this Authorization at any time by contacting the Originating Entity indicated above. I understand that once my health information is used or disclosed, it is no longer protected by state or federal law.

I understand that neither BJC HealthCare nor any of its affiliated healthcare providers, nor Washington University can make me sign this Authorization as a condition for getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless Federal Privacy Regulations allow it. I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the Notice of Privacy Practices.

I understand that I am entitled to a signed copy of this Authorization.

Name of Individual _____ Date of Birth _____

Street Address _____ City, State, ZIP Code _____

Email Address _____ Phone Number _____

Signature of Individual, Guardian or Representative _____ Date _____ Time _____

Representative's Relationship to Individual _____ Phone Number _____

Signature of Employee Witness _____ Date _____ Time _____

DO NOT WRITE BELOW THIS LINE