For Staff Use Only:	Name of Staff Person:
Location of photo(s):	
Purpose of photo(s):	
Situation:	
Participant's gender: M / F	Description (clothing, hair color):

Release and Authorization to Photograph/Video and/or Disclose Protected Health Information

Please check all that apply:

Photography/Video

☐ I hereby authorize Children's Health Care d/b/a Children's Hospitals and Clinics of Minnesota (Children's) to take and use photographs/video of _____ (Participant's Name) for all Children's-related promotional materials, marketing and social media efforts, fundraising activities and/or media productions. This release applies to images in print, digital, video, and broadcast formats.

Disclosing Protected Health Information

☐ I hereby authorize Children's to share the name, health history, including diagnosis, and treatment story of _____("Patient") for all Children's related promotional materials, marketing and social media efforts, fundraising activities and/or media productions. I understand this information is Protected Health Information and that Children's cannot disclose this information without my authorization, which I am hereby giving.

Acknowledgements

1. I understand that Children's has the right to use, edit, display, broadcast, distribute and reproduce these images and/or information in any form and may share these images and/or information with other media. I understand I will not be given the opportunity to inspect or approve the final product.
2. I understand Children's owns the rights to any images created pursuant to this authorization, and I release all claims against Children's and other media with respect to copyright and publication.
3. I understand that this material and/or information may be used in Children's advertising, marketing materials, on its website and/or social media pages.
4. I understand that this material and/or information may be shared with the general public. I agree that Children's is not responsible for any misappropriation of the photographs/video, if applicable, by any member of the general public or news.
5. I understand that I will not receive compensation of any kind for the use of the photographs/videos and/or the sharing of the Patient's Protected Health Information or any other materials created pursuant to this authorization.
6. I understand that refusal to grant authorization to Children's to create and use photographs/video of me/the Patient and/or share the Patient's Protected Health Information will not affect the services I/the Patient receive(s) at Children's.
7. If a member of Children's staff, I understand that refusal to grant authorization to Children's to create and use photographs/video of me will not affect my position or employment at Children's. Children's CE #: _____.

Revocation of Authorization

When Children's is conducting the photographing or videotaping, you may ask us to stop at any time. You may revoke your authorization to use the photographs/videos and/or share the Patient's Protected Health Information any time up to the actual production of any materials that have not yet been created at the time of your revocation. However, once the material is produced, you may not revoke your authorization for Children's to use the material. The option to stop production or use does not apply to the news media, as they are not under Children's control. This authorization will expire only upon receipt of a written revocation and will apply only to those materials not yet produced.

My signature below acknowledges that I have read, understand, and agree to the statements set forth above in this document.

_____	_____
Signature (Patient/Parent/Guardian)	Date and Time
_____	_____
Print Name	Relationship to Participant
_____	_____
Address	Phone Number
_____	_____
Email Address	Children's Staff Signature