PHOTO AND MEDIA RELEASE

Photo Release and Authorization/Consent for Use or Disclosure of Protected Health Information for Publication Purposes

Person: ____ Date: ___________________________

CP Rochester Program(s): ____

I hereby consent to the taking, publication, and/or broadcast of photographs (or other likeness of me), videotapes, audio tapes, and any other form of visual/audio media being taken for CP Rochester and its related or affiliated agencies with full knowledge these productions may appear on television, radio, on the Internet, or in print. I also consent to the release of my name, my residence, program attended, and my image.

I permit CP Rochester to use the materials in any of its or its related/affiliated agencies' brochures, advertisements, displays, flyers, web sites, or public/private information pieces. I hereby waive all rights to claims for payment or royalties in connection with the use, publication, or exhibition of the above mentioned materials. I fully understand that usage of these materials may not relate to my image. Any restrictions of use must be stated below and initialed.

- I understand the purpose of CP Rochester's usage of above mentioned items are intended to promote the services of the agency to increase public/private awareness, and to educate current and/or future consumers of CP Rochester which may result in the financial growth of the organization.
- I release CP Rochester, its staff, and its related or affiliated agencies of any responsibility or recourse in the taking or publishing of such materials as outlined above, now and in the future. I understand all materials will remain the sole property of CP Rochester. I understand I may revoke this consent at any time (for future usage only) by contacting the Marketing and Communications Department at 334-6000.
- I understand my released information (indicated above) may be re-disclosed by entities authorized by CP Rochester and may no longer be protected by federal privacy regulations.
- I may refuse to sign this form authorizing release of protected health information and my refusal to sign will not affect my ability to obtain treatment or payments except in some situation when such information is needed for payment and enrollment.
- I may, in accordance with applicable agency Privacy Policy, inspect or copy any information used or disclosed under this authorization upon request and obtain a copy of this form if I ask for it.
- I understand this signed authorization remains effective for three (3) years following the date signed.

_______________________________________ _______________________________

Signature of Person Witness

_______________________________________ _______________________________

Signature of Representative *(if minor or unable to sign)* Relationship

(initial) _______ Restrictions (if any): ____

____

Revised 9/16/13