KETTERING Health Network

MARKETING & COMMUNICATIONS
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Photographic, Video, Audio, and Web Site Information

AUTHORIZATION AND RELEASE FORM

I do hereby authorize the Kettering Health Network, its staff, agents, and assigns to take photographs of me, record video or audio of me (and/or my property), and/or to write an article about my story, actions, or conduct. I acknowledge that the tapes, photographs, films, or articles may be used for educational, professional, medical, scientific, or promotional purposes. I further understand that my health information and likeness may also be used in Kettering Health Network brochures; publications; booklets; or may be used in commercial news media, including, but not limited to, newspapers, magazines, radio, television, films, or the Internet.

I further acknowledge that my health information, including but not limited to my name, likeness, identity, and any information I have shared concerning my treatment may be revealed therein or by descriptive text or commentary.

I give to Kettering Health Network all rights to exhibit this work publicity or privately, including posting on the Internet. I acknowledge that all photographs, films, and tapes (whether they are originals, copies, negatives, or proofs) shall become the property of Kettering Health Network and those items may be used, produced, reproduced, or distributed without obtaining my prior approval.

I waive any rights, claims or interests I may have to control the use of my health information, identity, or likeness in the photographs, video, audio, or articles, and agree that any uses described herein may be made without compensation or additional consideration of me. I hereby hold harmless and release forever Kettering Health Network from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I understand that I may withdraw this authorization in writing at any time by contacting Kettering Health Network Marketing. I understand that Kettering Health Network may not be able to honor my request to withdraw this authorization with regard to any information that has already been released. I understand that, unless I withdraw this authorization, it shall remain in effect until Kettering Health Network's use of my information, identity, or likeness has ended. I understand that the entities or individuals that receive the materials containing my health information, identity, or likeness may not be covered by federal privacy regulations, and that the information may be used again by the recipient.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.

I represent that I have read and understand the foregoing statements and am competent to execute this authorization.

Name: _____ Signature: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Date: _____

Witness: _____ Witness: _____

I am under 18 years of age, my parent/guardian agrees (parental signature required.)

Name of Parent/Guardian: _____

Signature: _____ Date: _____