

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION  
FOR PUBLICITY**

As the parent or guardian of the minor child(ren) identified below, I authorize Seattle Children's to use or disclose protected health information for publicity, including but not limited to: newspaper, magazine, radio, videotape, Web sites, and other published material.

**Information to be used or disclosed:**

I authorize the use of my child(ren)'s name, age, sex, date of admission and discharge, city of residence, general nature of injury/illness, condition, treatment and prognosis, if applicable, and voice and image in photograph, video, or audio recording, for treatment period which began: \_\_\_\_\_.

**Please withhold the following information:** \_\_\_\_\_

**Information may be used by or disclosed to:**

**Please check box(es) that apply:**

- Media outlets or news agencies (such as TV, radio and newspapers)  
 Seattle Children's Hospital Foundation / Seattle Children's Hospital Guild Association  
 Other: \_\_\_\_\_

I understand that once Children's discloses this information and/or material, the person or organization that receives it may re-disclose it, and privacy laws may no longer protect it.

**This authorization for use or disclosure of protected health information expires 12 months from date signed, or as specified here:** \_\_\_\_\_

I can revoke this authorization by notifying Children's Marketing Communications Department by phone, in person or in writing. If I do revoke the authorization, it won't affect any actions that Children's has already taken based on this form. I understand that I don't have to sign this form for my child to get treatment from Children's. By signing this form, I acknowledge that I have read and agreed to its terms.

***THIS FORM DOES NOT AUTHORIZE THE DISCLOSURE OF WRITTEN OR PRINTED MEDICAL RECORDS***

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
 Printed Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Patient's Name: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Patient's Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_  
 Sibling Name(s): \_\_\_\_\_

**PHOTOGRAPHIC / VIDEO IMAGE / AUDIO RECORDING RELEASE FOR PUBLICITY**

I hereby give Seattle Children's and its affiliates the absolute and irrevocable right and permission to take, use, re-use, publish, and re-publish photographic/video images and/or audio recordings of: **First and Last Name/s:** \_\_\_\_\_  
 \_\_\_\_\_ in whole or in part, individually or in conjunction with other photographs, in any medium for publicity purposes, including without limitation, for purposes of illustration, promotion, advertising and trade. This authorization and release shall also inure to the benefit of the legal representatives, licensees, and assigns of the parties.

\_\_\_\_\_  
 Signature of Parent or Guardian                      Date

**Marketing Communications**  
**Seattle Children's**  
 P.O. Box 5371 / S-217  
 Seattle, WA 98145-5005  
 Phone: 206-987-5246

**WHITE:** Children's MarComm  
**YELLOW:** Other Dept.  
**PINK:** Patient/Family

Revised 10/20/2009

<b><u>For Children's Office Use:</u></b>	
<b>Event / location:</b> _____	<b>Children's contact:</b> _____
<b>Type of media:</b> _____	<b>Description of person/s photographed / recorded:</b> _____
<p><i>Usage of this content logged on reverse. If you are releasing new health information more than 90 days after the consent form was signed you need to get a new consent form to obtain permission to release the new info.</i></p>	

<b># of Uses</b>	<b>Usage / Vehicle / Outlet</b>	<b>Media Type</b>	<b>Date of Use / Publication</b>	<b>Children's Project Owner</b>
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