



**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 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 or video, 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 agencies or organizations (such as TV, radio and newspapers)
- Children's Hospital Foundation/Children's 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.

**Please check one box:**

- This authorization expires when Children's no longer maintains or stores this material.
- This authorization expires on \_\_\_\_\_ (Date or Event).

I can revoke this authorization by notifying Children's Communications Department by phone, in person or in writing at the address on the bottom of the page. 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: \_\_\_\_\_ Date: \_\_\_\_\_  
 Printed Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Sibling Name(s): \_\_\_\_\_ Address: \_\_\_\_\_  
 \*Witness: \_\_\_\_\_

**PHOTOGRAPHIC/VIDEO IMAGE RELEASE**

I hereby give Children's Hospital and its affiliates the absolute and irrevocable right and permission to take, use, re-use, publish, and re-publish photographic and video images 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                      Signature of Witness                      Date

Children's Communications Department, P.O. Box 50020/S-217, Seattle, WA 98145-5020 (206) 987-5246