AUTHORIZATION FOR PHOTO AND MEDIA RELEASE

Name *(please print)***:** _____

Age: _____ **Birthdate:** _____ **Phone:** _____

Address:_____

City:_____ **State:** _____ **Zip:**_____

1. I hereby authorize Ascension and its hospitals, affiliates, subsidiaries employees ("Ascension") to photograph, interview, use and publish my photographic or video image, or the photographic or video image of my minor child(ren) _____ [Insert name of child or children] or my property.
2. I understand that the photographic or video image, or media interview may be produced and released in any media form, including, but not limited to, internet, newspaper, television, radio and/or marketing materials, in whole or in part, with such alterations and changes as Ascension desires, and that the images or interview may appear separately or with my name or the name(s) of my minor child(ren) included in this Authorization.
3. I understand that the purpose of the use or release of the images and media interview will be for education, marketing or public relations purposes.
4. The use or release of the images or media interview may be made to the public through education, marketing and public relations efforts for commercial or noncommercial publications, exhibits, and/or on the intranet and internet.
5. I agree that all pictures, reproductions, negatives, tapes of any kind relating to the images, and materials relating to interviews are, and shall remain, the property of Ascension and its agents to whom permission has been granted. If I should receive any print, negative or other copy thereof, I shall not authorize its use by anyone else.
6. I agree that no advertisement, photograph or other material need be submitted to me for approval, and Ascension shall be without liability to me for any distortion or illusionary effect resulting from the publication of my video, picture, portrait, likeness, or comments.
7. I understand that my signing this Authorization does not obligate Ascension to make use of any photographic or video images or media interviews.
8. I understand that this Authorization can be revoked by me at any time by submitting a written request to Ascension Communications, 101 S. Hanley, Suite 1100, St. Louis, MO 63105.
9. I understand that my revocation will not apply in those instances in which Ascension has acted upon this Authorization prior to the revocation being received by Ascension.
10. I understand that the information released pursuant to this Authorization may be subject to re-disclosure and no longer protected by state and federal privacy laws.
11. I hereby release and discharge Ascension from any and all claims, actions, and demands arising out of or in connection with the use of any photographic or video images or media interviews without limitation.
12. I understand that Ascension cannot require me to sign this Authorization as a condition of providing treatment to me or my minor children or obtaining payment for treatment.
13. I understand that my signing this Authorization is voluntary, not a requirement of my employment at Ascension, and that I will not face any repercussions on my employment status if I so choose not to sign this Authorization.
14. This Authorization will expire on _____. If no specific date is indicated, this Authorization will expire in ten (10) years.

Patient Signature/Authorized Representative: _____ **Date signed:** _____

Relationship: _____ **Witness:** _____

A copy of this Authorization must be presented to the person signing the Authorization.

Ascension