Rady Children's Hospital-San Diego
3020 Children's Way, MC #5049
San Diego, CA. 92123-4282

DT74010

MEDIA RELATIONS

PATIENT INFORMATION

Media and Community Relations Authorization for Use, Disclosure or Publication of Photographs

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF INFORMATION

Patient's Name ______________________________________ ________________
Last First Middle Initial Birth Date

I, the undersigned, do hereby authorize ***Rady Children's Hospital - San Diego*** and the attending physician, to photograph or permit other persons to photograph, the above-named patient(s). The term "photograph" shall mean still photography in any format, as well as videotape and any other mechanical means of recording and reproducing images. This authorization is hereby granted to:

____
Name and Function of Person or Organization to which Disclosure is Made (Addresses available on request)

Date(s) of photograph: ________

The requested information shall be used for the following purpose: **Photographs, videotapes and/or patient family interviews and stories that may be used for the promotion of Rady Children's Hospital and its services. These may be published in Kids' NewsDay, Rady Children's Magazine or other print media; and/or posted on the Internet including Rady Children's Hospital website(s) and social media; and/or used for fundraising events and other public relations purposes, including local and/or national print and/or broadcast media.**

Requested Information shall be limited to the following:____

I waive the right to compensation for the disclosure I have authorized and hold Rady Children's Hospital San Diego and the attending physicians and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

EXPIRATION

This Authorization expires [insert date or event] or in 20 years: ______________________________

RESTRICTIONS

California law prohibits the requestor from making further disclosure of my health information unless the Requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I understand that I have the following rights with respect to this Authorization:

- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: *Rady Children's Hospital and Health Center*, 3020 Children's Way, MC 5049 San Diego, CA 92123-4282.
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this Authorization.
- I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.

APPROVAL

Signature	Date	Witness
Relationship to Patient	Area Code and Phone Number	