

## Consent for Use and Disclosure of Photograph, Video, Audio and Interviewing for Marketing, Media, Education or Performance Improvement Purposes

Patient's Name (print) \_\_\_\_\_

Address \_\_\_\_\_

**I hereby give my consent to Logan Health and/or its affiliates\* (collectively, “Logan Health”) to:**

- ☐ Use and disclose photographs, audio recordings, video images or other images of me for the purposes of:  
 \_\_\_ internal education \_\_\_ marketing \_\_\_ fundraising \_\_\_ social media campaigns \_\_\_ birth announcement \_\_\_ Other
- ☐ Use and disclose photographs, audio recordings, video images or other images of my child(ren) (under 18 years old) for the purpose of:  
 \_\_\_ internal education \_\_\_ marketing \_\_\_ fundraising \_\_\_ social media campaigns \_\_\_ birth announcement \_\_\_ Other

Name(s): \_\_\_\_\_

- ☐ Interview ☐ me  
☐ my children as indicated above  
☐ my healthcare providers
- ☐ Use and disclose audio recordings of my interview
- ☐ Live video stream my procedure using a two-way interactive HIPAA-compliant video platform

**GENERAL TERMS:**

- I understand that the photographs, audio, video or publicity purposes may be used for publications and/or broadcast by the media, for public affairs purposes, including publications, advertisements, displays and/or placement on Logan Health's website.
- I understand that once the news media interviews and/or photographs the patient, the media owns all rights to that footage and Logan Health has no authority over where or when it is displayed. The footage can be used how the new media sees fit throughout the world in perpetuity.
- I hereby waive all rights that I may have to any compensation in connection with the use of these photographs, audio recordings, video images and interviews, and agree that these shall at all times be the property of Logan Health or the media representative present.
- I acknowledge that by signing this Consent, I am consenting to the taking, use and disclosure of photographs, audio recordings, video images or interviews that may contain my protected health information.
- This Consent expires in 21 years, unless I notify the Logan Health, Health Information Management Department in writing that it will expire on an earlier date.
- I may revoke this Consent at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to: Logan Health, HIM Department, 310 Sunnyview Lane, Kalispell, MT 59901. Any revocation does not apply to the extent that action has already been taken in reliance on this Consent.

RELEASE:

I hereby release and hold harmless Logan Health and any of its affiliates, employees, trustees or agents from all liability claims, directly or indirectly connected with, arising out of, or resulting from, the activities authorized by this Consent.

Signature \_\_\_\_\_

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Printed name
Date

Relationship to Patient

Home Phone

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Cell Phone

Witness \_\_\_\_\_

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Printed name
Date

FOR OFFICE USE ONLY

Send all Consent forms to Logan Health Marketing. If Consent is from a patient, Marketing will send a copy to HIM for inclusion in the patient's medical record.

Marketing action: