Children's MINNESOTA

| For Staff Use Only: | Name of Staff Person: |
|---|---|
| Location of photo(s): | |
| Purpose of photo(s): | |
| Situation: | |
| Participant's gender: M/F | Description (clothing, hair color): |

## Release and Authorization to Photograph/Video and/or Disclose Protected Health Information

Please check all that apply:

**Photography/Video**

☐ I hereby authorize Children's Health Care d/b/a Children's Minnesota (Children's) to take and/or use photographs/video of my child for all Children's-related promotional materials, marketing and social media efforts, fundraising activities and/or media productions. This release applies to images in print, digital, video, and broadcast formats.

**Disclosing Protected Health Information**

☐ I hereby authorize Children's to share the name, health history, including diagnosis, and treatment story of my child for all Children's related promotional materials. Marketing and social media efforts, fundraising activities and/or media productions. I understand this information is Protected Health Information and that Children's cannot disclose this information without my authorization, which I am hereby giving.

**Acknowledgements**

☐ I understand that Children's has the right to use, edit, display, broadcast, distribute and reproduce these images and/or information in any form and may share these images and/or information with other media. I understand I will not be given the opportunity to inspect or approve the final product.

☐ I understand Children's owns the rights to any images submitted or created pursuant to this authorization, and I release all claims against Children's and other media with respect to copyright and publication. Submitted photos will not be returned.

☐ I understand that this material and/or information may be used in Children's advertising, marketing materials, on its website and/or social media pages.

☐ I understand that this material and/or information may be shared with the general public. I agree that Children's is not responsible for any misappropriation of the photographs/video, if applicable, by any member of the general public or news.

☐ I understand that I will not receive compensation of any kind for the use of the photographs/video and/or the sharing of the Patient's Protected Health Information or any other materials created pursuant to this authorization.

☐ I understand that refusal to grant authorization to Children's to create and use photographs/video of me/the patient and/or share the Patient's Protected Health Information will not affect the services I/the Patient receive(s) at Children's.

☐ As a member of Children's staff, I understand that refusal to grant authorization to Children's to create and use photographs/video of me will not affect my position or employment at Children's. Children's CE#:_____.

**Revocation of Authorization**

When Children's is conducting the photographing of videotaping, you may ask us to stop at any time. you may revoke your authorization to use the photographs/vides and/or share the Patient's Protected Health Information any time up to the actual production of materials that have not yet been created at the time of your revocation. However, once the material is produced, you may not revoke your authorization for Children's to use the material. The option to stop production or use does not apply to the news media, as they are not under Children's control. This authorization will expire only upon receipt of a written revocation and will apply only to those materials not yet produced.

My signature below acknowledges that I have read, understand, and agree to the statements set forth above in this document.

_____ Participant/Patient's Name

_____ Participant/Patient's Date of Birth

_____ Signature (Participant/Patient/Parent/Guardian)

_____ Date and Time

_____ Print Name

_____ Relationship to Participant/Patient

_____ Email address

_____ Phone number

# Consent and Authorization for Photography, Recording or Broadcast

*Staff: Complete for photography, recording or broadcast* ***by or for Allina Health***
*(or by someone acting on behalf of Allina Health)*
*NOT for Media Consent – See Media/External Party Consent Form*

**PART 1:**
## Consent to Create and/or Use Photos, Recording or Broadcast

I agree that Allina Health or its representatives may **use existing images or recording or may create photographs, voice or audio recordings, or broadcasts of images or recordings** of me as indicated here: *(Check all that apply)*

☒ Photograph ☒ Audio Recording ☒ Video Recording ☒ Broadcast
☐ Other: _____

The **purpose** for which the photograph, recording or broadcast will be created or used is:
Internal and external communications, including: Internal staff newsletter and website, electronic message boards, news media/press release (if applicable), social media (Facebook), Allinahealth.org website, other marketing materials (if applicable).

I understand that:

- I can ask to stop the photography, recording or broadcast at any time before it starts or while it is happening.
- If I am a patient, I have the right to cancel this consent before the images, recordings or broadcast are used.

I agree that:

- All images or recordings and/or copies will be the exclusive property of Allina Health,
- Allina Health may keep or use the images or recordings now or in the future.
- Allina Health may use personal information about me in connection with the photograph, recording or broadcast, which may include my name, health information and other personal information that I provide to Allina Health.
- Allina Health does not owe me any payment for any benefit it receives for the use of my images or voice, including for marketing or publication of the images or recordings.

_____
Printed Name of Person in photograph, recording or broadcast Date of Birth

_____
Signature *(If person in photo or recording is under age 18, a parent/guardian must sign)* Date

_____
Authority to sign if signing on behalf of patient (Relationship to Patient)

***Continue to PART 2 if identifiable Protected Health Information (PHI) about a patient will be used in connection with the image, recording or broadcast.***

**PART 2**

# Authorization for Allina Health to Use and Release Health Information with a Photograph, Recording or Broadcast

*Staff: Complete if identifiable Protected Health Information (PHI) about a patient will be used in connection with the image, recording or broadcast.*

I authorize Allina Health and providers who deliver care to me at or for Allina Health to use and disclose my health information in connection with the photographs, recording or broadcast described in Part 1.
My health information may be used and disclosed for the purposes described in the Consent Form in Part 1.

- The health information that may be used or disclosed is:

  ☒ All health information that relates to the purpose ☐ Medical Records

  ☐ Other *(Select all that apply and list specific information that may be used/disclosed):*
  ☒ Name ☒ DOB ☒ Physician name ☒ My association with Allina Health
  ☒ Photograph ☐ Audio ☒ Recording ☒ Video recording

  Only information discussed with and known to you will be used.

  Allina Health records may include records that it received from other organizations. If these records have been used by Allina Health and filed in the record Allina Health maintains about you, these records may be released with your Allina Health records.

- This health information may be viewed or heard by any audience that Allina Health determines for the photograph, recording or broadcast. The expected audience includes: *(e.g., public, social media, Medical or Nursing School students, conference attendees, news broadcast)*
  Social media (such as Facebook), Allina Health staff, news media (as applicable), patients, general public
  _____.

- Allina Health cannot prevent re-disclosure of the health information by anyone who receives the information under this authorization, and the information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Allina Health from any and all liability resulting from a re-disclosure by the recipient(s).

- The health information can be used or disclosed in written or audio form
  *Select one:* ☐ **I DO** ☐ **I DO NOT**
  agree to allow my treating providers to release my health information in discussions, comments, interview or similar related to the images or recordings

- This authorization lasts for 10 years after the date you sign it unless you enter a different date or expiration here:_____. This authorization may be canceled in writing at any time. A cancellation will not change uses or releases that happen before the cancellation. The Allina Health Notice of Privacy Practice describes how to cancel (revoke) this authorization

- Allina Health will not restrict your treatment if you choose not to sign this authorization.

Your signature indicates that you have read and understand this form, and authorize release of your information as described above. A photocopy/fax of this authorization will be treated in the same way as an original.

_____
Patient Signature Date

_____
Authority to sign if signing on behalf of patient (Relationship to Patient)