Chicago Methodist Senior Services

Volunteer & Intern

Photograph/Video Release

HIPAA Authorization & Consent

Individual Name: _____

(Please print in ink or type)

I consent to the taking of photographs, video recordings or other images of myself for the purposes of Chicago Methodist Senior Services' (CMSS) website, newsletters, brochures, annual reports/performance reports, and social media.

I do hereby give (CMSS), it's assigns, licensees, successors in interest, legal representatives, and heirs the revocable right to use my name (or any fictional name), picture, portrait, or photograph in all forms and in all media and in all manners, without any restriction as to changes or alterations (including but not limited to composite or distorted representations or derivative works made in any medium) for advertising, trade, promotion, exhibition, or any other lawful purposes, and I waive any right to inspect or approve the photograph(s) or finished version(s) incorporating the photograph(s), including written copy that may be created and appear in connection therewith. I understand that CMSS will receive remuneration related to the use or disclosure of the requested information.

I hereby release and agree to hold harmless CMSS, it's assigns, licensees, successors in interest, legal representatives and heirs from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form whether intentional or otherwise, that may occur or be produced in the taking of the photographs, or in any processing tending toward the completion of the finished product, unless it can be shown that they and the publication thereof were maliciously caused, produced, and published solely for the purpose of subjecting me to conspicuous ridicule, scandal, reproach, scorn, and indignity. **I am of full age*and competent to sign this release.** I agree that CMSS owns the copyright in these photographs and I hereby waive any claims I may have based on any usage of the photographs or works derived there from, including but not limited to claims for either invasion of privacy or libel. I agree that this release shall be binding on me, my legal representatives, heirs, and assigns. I have read this release and am fully familiar with its contents.

*** Delete this sentence if the subject is a minor. The parent or guardian must then sign the consent.**

Authorization Statements/Signatures:

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to CMSS' Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. This authorization will expire (insert date or event): _____.
   If no date or event is specified, this Authorization will expire when CMSS ceases operations.
4. I understand that CMSS will not condition the provision of treatment on my signing of this authorization.

☐ I Agree (Please check this box if you agree).

Signed: _____ Date: _____
(If completing from your computer please type your full name)

---------- **Consent (if applicable)** ----------

I am the guardian of the individual (or minor) named above and have the legal authority to execute the above release. I approve the foregoing and waive any rights in the premises.

☐ I Agree (Please check this box if you agree).

Signed: _____ Date: _____
Parent or Legal Guardian
(If completing from your computer please type your full name)

Revocation

Date Revoked: _____
Initials of Privacy Officer_____