HCA
Hospital Corporation of America℠

RESEARCH MEDICAL CENTER

*This Form to be used in conjunction with the Form entitled "Authorization for Use and Disclosure of Protected Health Information For Marketing and/or Promotional Purposes"

CONSENT FOR USE AND DISCLOSURE OF IMAGE, VOICE AND/OR WRITTEN TESTIMONIALS

For good and valuable consideration, receipt of which is hereby acknowledged, I authorize HCA Management Services, L.P., and its affiliates (collectively, "HCA") and its respective parents, affiliates, subsidiaries, licensees, successors, and assigns to videotape and/or photograph me and record my voice, conversations, and sounds, including the right to publish any verbal or written statements, testimonials or biographical information I may provide regarding HCA and its services, employees or staff, and including photographing, taping, and/or recording my medical condition(s) or treatment(s) (collectively, the "Materials"). I understand that for purposes of this consent, the terms "image," "voice" and "photograph" encompass still photographs, digital images, audiotapes and any other method to reproduce or edit my likeness, image or voice, now known or hereafter developed.

HCA shall be the owner of the results and proceeds of such taping, photography, and recording with the right, throughout the world, an unlimited number of times in perpetuity, to copyright, to use, to publish, and to license others to use in any manner, including on the Internet, all or any portion thereof or of a reproduction thereof, free of any payment, royalty, or other compensation of any kind to me. I expressly understand and agree that the Materials and all results and proceeds derived therefrom, shall be the sole and absolute property of HCA for any and all purposes whatsoever in perpetuity, free and clear of all claims whatsoever by me and/or on my behalf. I further represent that any statements made by me during my appearance or in the Materials are true to the best of my knowledge and that neither they nor my appearance will violate or infringe upon the rights of any third party. I hereby represent and warrant that I have not given any other person, entity or firm the exclusive right to use by name, likeness, voice or photograph, and that by signing this document I am not in breach of any other agreement to which I am a party.

I hereby waive any right of inspection or approval of the Materials and my appearance in such Materials and the uses to which such Materials may be put. I agree that the Materials may be edited in the sole discretion of HCA and that HCA is under no obligation to use the Materials. I acknowledge that HCA will rely on this permission potentially at substantial cost to HCA and hereby agree not to assert any claim of any nature whatsoever against anyone relating to the exercise of the permissions granted hereunder.

I hereby acknowledge that I am solely responsible for any statements made by me during the recording of my voice and/or likeness as described above, which statements shall consist solely of my opinions and do not necessarily represent those of HCA, which is not responsible for the content of such statements. I hereby forever release and discharge HCA, and its respective members, officers, employees, customers and representatives from any and all claims, demands, actions, liabilities and damages whatsoever arising out of or attributable to, in whole or in part, the use of the Materials.

I hereby acknowledge that neither HCA nor any of its agents or employees have made any representations or warranties of any kind with respect to any medical or other advice or information that I may receive in connection with my appearance and that I have not relied on any such representations or warranties in agreeing to participate in the recording of my voice and/or likeness as described above or in the execution of this Consent for Use and Disclosure of Image, Voice and/or Written Testimonials (the "Consent").

I am signing this Consent as my voluntary act and deed, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs and assigns. I understand that this Consent will be signed contemporaneously with the form entitled Authorization for Use and Disclosure of Protected Health Information for Marketing and Promotional Purposes (the "Authorization"), and I agree that in the event of conflict between the two documents, the terms of the Authorization shall govern.

Signature of Individual or Legal Representative: ____

Print Name: _________________________________ _____________Date: _________________

Relationship of Legal Representative to Patient (e.g., parent, guardian):
____

Authorization for Use and Disclosure of Protected Health Information For Marketing and/or Promotional Purposes

***This Form to be used in Conjunction with Form entitled "Consent for Use and Disclosure of Image, Voice and/or Written Testimonials"**

Facility: ____

Patient Identification

Printed Name: ____ Date of Birth: _______________________

Address: ____

____

Telephone: ___________________________________

Information To Be Released – Covering the Periods of Health Care

From (date) ____________________________________ to (date) _______________________________________

Type of information to be released: Video images, photographic images, conversations, sounds, audiotapes, verbal and/or written testimonials and statements, including biographical information, of the individual identified above.

Purpose of Request

To videotape, photograph and record audio of patients for the facility's marketing purposes, including but not limited to production of recordings, brochures, advertisements, videos and similar image and sound capture for purposes of publication and/or distribution via all types of media.

Payments to Facility

This marketing activity involves direct or indirect compensation/payment from a third party to the facility for this use of protected health information. ***Check One*: ☐ Yes ☐ No __________ Initials**

Persons Authorized to Receive Information

I agree that the publication and distribution of the protected health information described herein may and likely will include distribution of such information to the general public via various methods, including all types of media outlets (e.g., TV, radio, newspaper, Internet) for the facility's marketing purposes. I also understand that the facility may hire third parties to capture the image and/or voice of the individual identified above, and that my information will be used and disclosed by these third parties as instructed by the facility.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if any videotape, photograph or audiotape references drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

***Check One:* ☐ Yes ☐ No __________ Initials**

Expiration & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at ____. Unless revoked, this authorization will expire on the following date or event: __________________________________.

In the event that facility has relied on this authorization to create marketing and/or other promotional materials featuring my likeness (e.g., photographs or video), audiotapes of my voice, my name, my testimonial or recommendation and/or other information released pursuant to this authorization, I understand and agree that facility shall retain the right to use my likeness, voice, name, testimonial and/or other information until such time as all such marketing and/or promotional materials then in existence at the time of any revocation of this authorization are distributed, disseminated or expire. Any revocation of this authorization will become effective only after all marketing and/or promotional materials are distributed, disseminated or expire.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by anyone receiving it, and the information disclosed will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that facility may not condition treatment, payment, enrollment, or eligibility for benefits for the individual identified above on whether I sign this authorization form. I may inspect or copy the protected health information to be used or disclosed. **I authorize the facility to use and disclose the protected health information specified above for the purposes set forth above.**

Signature: _________________________________ Print Name: ________________________________ Date: _____________

Authority to Sign if not patient (e.g., parent, guardian): ____

Identity of Requestor Verified via: **☐ Photo ID ☐ Matching Signature ☐ Other, specify** _____________________________

Verified by Facility Employee (Signature): ____