DCH Ambassador Family Program

Application

Patient First and Last Name _____

Nickname _____

Age _____ DOB _____ ☐ Male ☐ Female Grade _____

Diagnosis _____

Date of diagnosis _____

Are you currently being treated? _____ Allergies _____

What departments/doctors do you visit/have visited? _____

_____

_____

Address _____ City _____ ST _____ ZIP _____

Parent/Legal Guardian Name _____ Relationship to patient _____

Email address _____ Cell phone _____

Parent/Legal Guardian Name _____ Relationship to patient _____

Email address _____ Cell phone _____

Do you prefer phone calls or texts? To which parent? What is the best time to contact you?

_____

Names and ages of patient's siblings _____

_____

_____

Patient and family members' shirt sizes _____

_____

_____

_____

What is the patient's favorite thing about Driscoll?_____

_____

_____

_____

Favorite Driscoll staff member?_____

Favorite school subject? _____

Favorite food?_____

Favorite sports team? _____

Favorite movie? _____

Favorite color?_____

Hobbies or favorite things to do?_____

What else should we know about the patient? _____

_____

_____

For questions or to return completed form:

Veronica Ramos
Assistant Annual Giving Specialist, Development
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(361) 694-4485

Driscoll Children's Hospital
3533 S. Alameda Street
Corpus Christi, Texas 78411

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Driscoll Children's Hospital

AUTHORIZATION AND RELEASE FOR THE USE and/or DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING AND MEDIA USE

Patient Names: _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: (_____) _____

I hereby give Driscoll Health System (DHS) and/or its representatives (***which may include DHS employees, medical staff and health care team members, administrators, Board Members and donors and supporters***) as well as the news media or other parties interested in the care and treatment of my children – the right to interview, photograph, videotape/film, audio tape or digitally record me, my children and other family members and my children's healthcare providers. I authorize the use and disclosure of the information below for any of the following purposes:

- Marketing and promotional material (such as videos, brochures, flyers, pamphlets, posters);
- Media accounts (television, radio, newspapers, magazines, other print, Internet and social media web sites such as Facebook, twitter);
- Advertising and fundraising in any media; and
- Scientific, educational, staff development, quality assurance or performance improvement presentations and publications.

I agree that <u>any</u> of the following types of information may be used or disclosed according to this Authorization:

- Photographs, video, audio, digital and other recordings, and live stream broadcast of my child's care and treatment at DHS;
- Interviews or quotations made by me or my child, my child's healthcare providers or about me or my child; and
- Protected Health Information (which may include the patient's name and information about the patient's diagnosis, condition, treatment and procedures).

I understand that I have the right to refuse any of the above uses as indicated below. (*If applicable, please describe any information that is not to be disclosed pursuant to this Authorization*):

_____
_____

This Authorization is effective until the patient reaches the age of majority or sooner by your choice (in which case this consent will expire on _____, _____). This Authorization may be revoked at any time except to the extent that the use or disclosure has already occurred prior to your request for revocation. There is a potential for information disclosed pursuant to this Authorization to be subject to re-disclosure by the recipient, and therefore no longer protected by the HIPAA Privacy Rule. In order to revoke this authorization, you must notify in writing Driscoll Children's Hospital at 3533 S. Alameda St., Corpus Christi, TX 78411 ATTN: MARKETING.

The information collected pursuant to this Authorization becomes the property of Driscoll Health System and its representatives and may be used without further notice to you. You agree to release to Driscoll Health System any right, title or interest in the information obtained and produced.

This Authorization is given without promise of compensation. Driscoll Health System will not condition treatment, payment, enrollment, or eligibility for benefits on the execution of this Authorization.

By signing this Authorization, you agree to release, discharge, and hold harmless Driscoll Health System and its directors, officers, employees. and agents from any and all claims, actions and demands of any nature arising out of or in connection with the information covered by this Authorization.

I fully understand the above Authorization and give my consent as set forth above.

Signature of Parent or Guardian: _____ Date: _____
Printed Name: _____
Signature of Witness: _____
Printed Name: _____
Printed Name: _____

IF THERE ARE MORE CHILDREN IN YOUR CARE:

Patient/Child Information (please print)

Patient/Child Name: _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: (_____)_____

Patient/Child Name: _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: (_____)_____

Patient/Child Name: _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: (_____)_____

Patient/Child Name: _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: (_____)_____