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. 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 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: (______)_________________