Authorization for Media, Photographs, Videotaping, and Interviews

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special permission before we may use or share your protected health information with the news media and the general public as described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed.

Please read the information below carefully before signing this form. A representative of North Country Healthcare (NCH) is available to answer any questions regarding this form.

I agree to give North Country Healthcare (NCH) and/or their representatives, permission to:

☐ Take and use photographs or video of me for the purposes of publicity, education and/or marketing through internal publication, external publication, radio, television, video, social media, or internet publication by NCH.

☐ Provide my name, contact information, and any statements to: _____ _____ (name of media/news organizations if known) in connection with my treatment and experience as a patient, for the purposes of interviewing me. I understand that any further information disclosed by me/the patient to this external organization regarding my patient's treatment may be shared further.

Such photographs, video and/or interview content will disclose the fact that I have been a patient of an NCH provider and may contain other information about me, including information I share during the interview, other private health information, or facts that can be inferred from the content.

I understand that:

- I am not required to sign this form in order to receive treatment for my care.

- Information used or disclosed under this authorization may be reused by the recipient and will no longer be protected by privacy regulations.
- I may revoke this authorization at any time by notifying NCH in writing, and the revocation will be effective on the date notified (except to the extent action or publication has already been taken based on my earlier authorization, in which case we will attempt to remove the media, photograph, video from our system but cannot recall uses outside of our control).
- Neither I nor NCH will receive direct or indirect payment for the communication related to this media, photo, video, or interview.

When completed, this form will be kept by Public Affairs, Marketing or Communications staff or other appropriate, authorized person.

_____

Name of Patient/Participant

_____

Street Address

_____

City, State, Zip

_____

Email Telephone

☐ I am the patient/participant

☐ I am the Parent/Legal Guardian/Personal Representative (If patient/subject is under 18 or incapable of signing)

_____

Signature Date