Patient/Member consent for Sentara Communications & Marketing to use or disclose protected health information, including photo/video/audio recordings & interviews

PATIENT NAME (PLEASE PRINT) _____ PATIENT DATE OF BIRTH _____

I AUTHORIZE: **Sentara Health and its affiliated entities, employees, licensees, affiliates, contractors, successors and assigns (together, "Sentara")**

TO DISCLOSE: Patient or member medical information about care, treatment, and diagnosis regarding the patient identified above.
Limitations, if any: _____

AND CONSENT TO: Photos, videos, audio recordings, interviews, quotes written with/about the patient or member identified above to be made, biographical information, used, reproduced, and/or published by Sentara and its affiliates.

TO: Sentara-owned publications, social media channels and web sites, including, but not limited to Sentara.com, Sentara and its affiliated social media accounts, as well as all public media outlets, including, local, regional, national and international print, broadcast, and internet media.

FOR THESE PURPOSES: Communication, promotion, education, public relations, and marketing by Sentara.

- I understand and agree that these images and interviews, including my image, likeness, and/or voice, may be used in the news or by Sentara for purposes of education, promotion, public relations, and/or marketing, and that they may appear in print, on television, in radio broadcasts, or on the internet. I understand that there is a possibility that I may be identifiable in these photographs, videos, or written/audio accounts, though my name may not be published unless specifically agreed to below.

❑ I DO ❑ I DO NOT consent to the use of my name/the patient's name in conjunction with photographs or videos.

- I agree to release and hold harmless Sentara, its officers, directors, trustees, employees, and agents from any and all liability which may arise from the making of or use of these photographs, videotapes, or interviews, and I will not request payment for the use of my image or likeness. Sentara will not receive remuneration, including cash payments, for any disclosure pursuant to this authorization.
- I understand that I have the right revoke this authorization at any time by sending a written notice to privacy@sentara.com. I understand that the revocation will not apply to information that has already been released in response to and reliance upon this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will not have an expiration date.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules and regulations. I understand that Sentara cannot prevent reuse by someone other than Sentara. I release Sentara from any liability that may come directly or indirectly from the disclosure allowed by this authorization and/or any reuse of my likeness.
- I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility for benefits.
- I certify that I am the patient, the patient's parent, or patient's legal guardian authorized to disclose this patient's protected health information.

NAME OF PATIENT/AUTHORIZING INDIVIDUAL (PLEASE PRINT) _____ **DATE** _____

SIGNATURE OF PATIENT/AUTHORIZING INDIVIDUAL _____ **RELATIONSHIP TO PATIENT/AUTHORIZING INDIVIDUAL** _____

ADDRESS (STREET, CITY, STATE AND ZIP) _____ **PHONE NUMBER** _____

STAFF USE:

Sentara®