



Photography, Video, Audio, and Website Information

Authorization and Release Form

I do hereby authorize Kettering Adventist Healthcare, an Ohio nonprofit corporation, dba Kettering Health, and its subsidiaries, affiliates, staff, agents, and assigns (collectively, "Kettering Health") to take photographs of me, record video or audio of me (and/or my property), and/or to write an article about my story, actions, or conduct. I acknowledge that the tapes, photographs, films, or articles may be used for educational, professional, medical, scientific, promotional, or any other lawful purposes. I further understand that my health information and likeness may also be used in Kettering Health brochures, publications, or booklets, or may be used in commercial news media, including, but not limited to, newspapers, magazines, radio, television, films, or the internet.

I further acknowledge that my health information, including but not limited to my name, likeness, identity, and any information I have shared concerning my treatment, may be revealed therein or by descriptive text or commentary.

I give Kettering Health all rights to exhibit this work publicly or privately, including posting on the internet. I acknowledge that all photographs, films, and tapes (whether they are originals, copies, digital archives, negatives, or proofs) shall become the property of Kettering Health and those items may be used, produced, reproduced, or distributed without obtaining my prior approval.

I waive any rights, claims, or interests I may have to control the use of my health information, identity, or likeness in the photographs, video, audio, or articles, and agree that any uses described herein may be made without compensation or additional consideration of me. I hereby hold harmless and release forever Kettering Health from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I understand that I may withdraw this authorization in writing at any time by contacting Kettering Health Marketing and Communications at marketingandcommunications@ketteringhealth.org with the subject line "withdrawing consent." I understand that Kettering Health may not be able to honor my request to withdraw this authorization with regard to any information that has already been released. I understand that, unless I withdraw this authorization, it shall remain in effect until Kettering Health's use of my information, identity, or likeness has ended. I understand that the entities or individuals that receive the materials containing my health information, identity, or likeness may not be covered by federal privacy regulations, and that the information may be used again by the recipient.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.

I represent that I have read and understand the foregoing statements and am competent to execute this authorization.

Name _____ Signature _____

Address _____ City _____

State _____ Zip _____ Phone _____ Date _____

Witness _____ Witness _____

I am under 18 years of age, my parent/guardian agrees (parental signature required).

Name of parent/guardian _____

Signature _____ Date _____