MEDIA CONSENT

I consent and grant permission to Scottish Rite for Children, its staff, and its outside media representatives to photograph, video record, audio record, and interview me and my child/my ward.

I further consent and grant permission to Scottish Rite for Children to copyright, use, and publish the photographs/video recordings/audio recordings, along with the name, age, city of residence, and personal story of me and my child/my ward, all or some of which may include health information, to increase public awareness of the hospital and its patients, and for other hospital-related purposes/programs. I also consent and agree that, for the purpose of increasing public awareness of the hospital and its patients, and for other hospital-related purposes/programs, such photographs/video recordings/audio recordings, along with the name, age, city of residence, and personal story of me and my child/my ward, all or some of which may include health information, may be (1) published in newspapers, magazines, journals, textbooks, and other printed materials; (2) distributed to the press; (3) broadcasted on radio and television; (4) shared with outside entities/individuals associated with hospital-related purposes/programs; and (5) included in videos, audio recordings, websites, social media, and presentations.

I understand that I have the right to revoke this Consent at any time provided that it is in writing, except to the extent that Scottish Rite for Children has taken action in reliance thereon. To revoke this Consent, I understand that I should send my revocation in writing to Scottish Rite for Children, Attn: Privacy Officer, 2222 Welborn Street, Dallas, Texas 75219, or by email at privacyofficer@tsrh.org.

I understand that in the event of a conflict between this consent and any Authorization for Use and Disclosure of Protected Health Information for Marketing or Promotional Purposes ("Authorization") that I may provide to Scottish Rite for Children, the terms of the Authorization shall govern.

Name of Child: _____ Date of Birth: _____

Name of Parent or
Legal Representative: _____ Relationship to Child: _____

Address: _____ City, State: _____ Zip: _____

E-Mail: _____ Phone: (____) _____

Emergency Contact Name and Phone:
(if different from above) _____

Authorized Signature:
(Parent/Legal Representative or
Patient if ≥ 18/emancipated minor): _____ Date: _____

Originating Event Title:

S-271
9/2020