The principal teaching hospital for Tufts University School of Medicine

Tufts Medical Center

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PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PATIENT INFORMATION FOR FUNDRAISING, PUBLIC AFFAIRS & MARKETING ACTIVITIES

Patient Information:

Name:_____ Date of Birth: _____

Address/City/State/Zip _____

Home Phone #: _____ Alternate Phone #_____ Email: _____

I, the above-named patient, agree to be filmed, photographed, videotaped, and/or interviewed relative to my care and treatment at Tufts Medical Center.

Specifically, I give permission to be filmed, videotaped, photographed and/or interviewed, in connection with **Tufts Medical Center's fundraising, public affairs, and marketing activities.** I give permission to Tufts Medical Center to copyright, use and reuse these materials and reproductions and simulations of my likeness in printed publications, web sites and television and radio broadcasts (the "Product"). I understand that the Product may include, without limitation, Tufts Medical Center newsletters, brochures, website and electronic presentations, including donor presentations and program summaries, and testimonial stories highlighting the services and programs of Tufts Medical Center.

I give my authorization to allow my name to be used and my identity to be known in the Product. I authorize the use and disclosure of my name and demographic information and details of my diagnosis and medical care in the Product (unless limited as specifically noted below*).

I understand that I have the right to request cessation of recording or filming at any time. I understand that this Authorization will be in effect indefinitely unless otherwise specified here:

_____

I further understand that I have the right to rescind consent upon notice to Tufts Medical Center for use of the Product up until a reasonable time before the Product is used.

I have been informed that any films, videotapes, photographs and/or interviews relative to this Authorization shall not be considered part of my medical record. Such films, video tapes, photographs and/or interviews are the property of Tufts Medical Center and may be destroyed at any time at the discretion of Tufts Medical Center.

I understand that the Product may be generated in conjunction with the news media and/or may be distributed to the news media. I further understand that the Product may be edited as deemed appropriate. I understand that the Product may be used for publicity and/or informational purposes by Tufts Medical Center as Tufts Medical Center deems appropriate.

I am aware that I will not receive any financial compensation relative to the Product or its use.

I understand that whether I agree to participate or decide not to participate in the Product, the decision will in no way affect the care or treatment provided to me by the physicians or staff of Tufts Medical Center.

I hereby release and discharge Tufts Medical Center, its affiliates and its and their employees, medical staff, directors, officers, agents, successors, assigns, heirs, executors and licensees from any and all claims and demands arising out of or in connection with the use of the Product in accordance with the terms of this Authorization, including but not limited to any claims for defamation, invasion of privacy or infringement of copyrights or moral rights.

* I request the following limitations on use and disclosure of my images and information:

_____

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Signature of Patient _____ Date _____

Witness Signature: _____ Name: _____ Date: _____

FOR OFFICE USE ONLY

Title of Photo Shoot _____ Photographer _____

Dept/Division_____ Subject _____

Media Story Name_____ Media Outlet _____