Southcoast Health

Media Release Form
(For Non-Patients)

**** Denotes required information***

I, (*insert PRINTED name) _____, hereby grant permission to Southcoast Health System, Inc. and its affiliates (collectively, "Southcoast") to photograph, interview or otherwise record me on (*insert date) _____ for publicity, promotional and/or other advertising or marketing purpose(s) (collectively, the "Purpose"), all in accordance with the terms of this release (the "Release").

I hereby grant Southcoast the right, but not the obligation, to publish, display, reproduce, perform, distribute, transmit and otherwise use images, videos, recordings or other materials depicting my image, likeness, life story or name and taken, recorded or created during, used for or displayed in connection with the Purpose (collectively, "My Likeness"). I hereby grant Southcoast the right, but not the obligation, to publish, display, reproduce, perform, distribute, transfer and otherwise use any works of authorship, art, multimedia or other item created by me and generated, used, displayed or donated in relation to the Purpose (collectively, the "Works"). I agree that (a) My Likeness and the Works may be publicly shown and, in Southcoast's discretion, the Works may be offered for sale and/or promotion of Southcoast services; (b) the rights granted to Southcoast herein are for use in any medium, whether such medium is now known or hereafter becomes known, including but not limited to print and electronic media, including websites and for all purposes of illustration, promotion, advertising and trade; and (c) Southcoast may use My Likeness in connection with the Works and the exercise of its rights under this Release if it so chooses.

I hereby waive, or where I am a minor or lack capacity to enter into this Release, my parent, guardian or legal representative hereby waives, all of my rights in and to a royalty or compensation related to Southcoast's use of My Likeness and the Works in accordance with this Release. I, or if applicable, my parent, guardian or legal representative, hereby release Southcoast from, and shall neither sue nor bring any proceeding against Southcoast for, any claim or cause of action, whether now known or unknown, for infringement, defamation, invasion of right to privacy, publicity or personality or any similar claim, or based upon or relating to the authorized use and exploitation of the Works.

This Release shall remain in effect until it is rescinded by me. I reserve the right to cancel this Release by providing written notice to Southcoast. This Release shall only relate to Works created that use or incorporate information I disclosed to Southcoast in connection with the Purpose. This Release shall not reflect or extend to any subsequent events or information disclosures to Southcoast, or purposes unrelated to the Purpose. By signing this Release, I acknowledge that I have, or where the patient is a minor or lacks capacity, the patient's parent, guardian or legal representative acknowledges that he/she has, read and agree(s) to the terms of this Release.

I hereby agree that I have read the foregoing and fully understand and agree with its contents, or if I am a minor or lack capacity to enter into this Release, my parent, guardian

or legal representative acknowledges that he/she has read and agrees to the terms of this Release on my behalf:

_____ _____

***Signature** ***Date**

If above-named individual is a minor or lacks capacity to enter into this Release:

_____ _____

*Printed Name and Signature of Legal Representative Date

*Relationship to Individual:_____

**If other than Parent, Documentation of Legal Authority to Consent on Behalf of Patient May be Required*

_____ _____

Signature of Interpreter (if necessary) Date

Please scan and email a copy of this Release to:

_____

Or if not noted, to Marketing and Communications Team at marcomms@southcoast.org

This form can be sent via interoffice mail to Marketing and Public Relations

This form can also be mailed to:
Southcoast Health Marketing and Public Relations
157 Page Street
New Bedford, MA 02740

***OFFICE USE ONLY:**

*Name of Subject:_____

Subj. contact information:_____

*Date of content acquisition:_____

*Purpose/ Occasion of content acquisition:_____

*Type of Content Procured:_____

*Requested by/ for: (dept, person, project):_____

Southcoast Health

ONLY FOR USE WITH THE SOUTHCOAST MEDIA RELEASE FORM FOR PATIENTS

Please select the applicable entity (a separate authorization must be signed for each entity) (the "Treating Entity)":

☐ Southcoast Hospitals Group, Inc. ☐ Southcoast Visiting Nurse Association, Inc. ☐ Southcoast Physicians Group, Inc.

Physician Name: _____ MD/DO

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____
Street City State Zip

Home Phone:_____Alternate Phone:_____E-mail:_____

Information to be disclosed (select all that apply):

☐ Patient's name (first and last) and age ☐ Summary of diagnoses, services provided, and outcomes
☐ Patient satisfaction statements

☐ Patient photographs ☐ Patient videos ☐ Patient audio recordings ☐ Patient interviews

☐ Statements from patient's physician about patient's condition, diagnoses, services provided and outcomes

☐ Other (specify):

I hereby authorize the Treating Entity to disclose the protected health information described above. I understand that signing this authorization is voluntary and that my health care at the Treating Entity will not be affected if I do not sign this form. I understand that information disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Information to be disclosed to:

☐ Southcoast Health System, Inc.

☐ Other (specify):

Disclose information for the following treatment dates:

☐ All information maintained by the Treating Entity (as defined above).

☐ Other (specify): From _____/ _____/_____ to _____/_____/_____

The above information is disclosed for the following purposes:

☐ Advertising, marketing and promoting Southcoast's services within Southcoast and to the general public through media of general circulation, such as newspapers, radio advertisements, online advertisements, print advertisements and/or television advertisements.

☐ Other:

Unless earlier revoked, this authorization will expire ONE YEAR from the date of my signature on this form.

Southcoast cannot use or disclose certain information unless you specifically authorize such use or disclosure. Please select any applicable items below and sign and date where indicated only if you specifically authorize the release of health information relating to the testing, diagnosis or treatment for any of the following:

☐ Mental Illness ☐ AIDS/HIV Information or Test Result ☐ Genetic Testing ☐Drug Treatment /Testing
☐ Alcohol or Test Results ☐ Sexual or Physical Abuse ☐ Socially Transmitted Disease/Test Results

Signature of Patient or Legal Representative	Date
Name of Patient or Patient's Representative	Relationship to Patient or Authority to Act for Patient

By signing below, I understand and acknowledge that:

- I have read and understand this authorization.
- I am authorizing Southcoast to use or disclose health information to the person(s) and for the purpose(s) identified in this authorization.
- I understand that the information released pursuant to this authorization may no longer be protected by law or regulation of the release and may be re-disclosed.
- I may revoke this authorization at any time by requesting such from Southcoast in writing, except to the extent that action has already been taken in reliance on this authorization. I understand that a description of my right to revoke my authorization is set forth in Southcoast's Notice of Privacy Practices.

***Signature of Patient or Legal Representative**	***Date**
*Printed Name of Patient or Patient's Representative	*Relationship to Patient or Authority to Act for Patient

Legal authority of representative verified by:_____

A copy of this signed authorization must be provided to the patient.

Please scan and email a copy of this to:

Or if not noted, to Marketing and Communications Team at marcomms@southcoast.org

This form can be sent via interoffice mail to Marketing and Public Relations

This from can also be mailed to:
Southcoast Health Marketing and Public Relations
157 Page Street
New Bedford, MA 02740