PA 15579

Authorization for use and release of information and images

Boston Children's Hospital
Until every child is well™

Patient

First name _____

Last name _____

Date of birth ____ ____ ____
Month Day Year

Legal guardian

First name _____

Last name _____

Relation to patient _____

Address and contact information

Address _____

City _____

State _____ Zip _____

Home phone _____

Work phone _____

E-mail _____

Authorization

I authorize Boston Children's Hospital to use this information for marketing, fundraising and public relations purposes.

- I authorize Boston Children's to photograph and record (in broadcast, on film, images, videotape, digital media formats, sound recordings or otherwise) me or my child(ren) during interviews, celebrations or events, diagnostic and/or treatment sessions, operations and/or other surgical or medical procedures at Boston Children's.
- I authorize the use and release of my or my child's name, details of his/her medical care and demographic information, and such photographs and recording obtained from situations described above to Boston Children's.
- I am aware that Boston Children's cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Boston Children's may or may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below.
- I can, however, cancel this authorization in writing at any time, except in cases where Children's has already released information or an image. For example, Boston Children's will not be able to retract a TV Segment once it has been aired and will not be able to fully retract a story, image or video once it has been placed on the Internet. All revocations must be sent in writing to: Boston Children's Hospital, Marketing and Communications, 300 Longwood Avenue, Boston, MA 02115.
- I authorize Boston Children's to use this information for fundraising and marketing and to appear in all media, including print, broadcast, internet and online. This includes social media networks (e.g., Facebook, YouTube, etc.), to promote or publicize or fundraise for Boston Children's.
- I understand that the care provided by Boston Children's will not be affected if I do not authorize this release.

Signature Legal guardian or patient (if age 18 or older).

X _____

Date ____ ____ ____
Month Day Year

Expiration

This authorization will expire on: Date ____ ____ ____
Month Day Year

Please return this completed form to: Boston Children's Hospital, Marketing and Communications, 300 Longwood Avenue, Boston, MA 02115.
If you have any questions about this form or how your information will be used please contact us at 617-919-3110 or marcom@childrens.harvard.edu.

For internal use

Boston Children's staff:

Phone:

E-mail:

Event or purpose:

Date of recording:

Location:

Description of child:

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