*California Hospital Association Adventist Health Communication*

*Form 24-4 (03/10) Office number: 559-537-0090, email:* [AlvareVF@ah.org](mailto:AlvareVF@ah.org)

**CONSENT TO PHOTOGRAPH AND**

**AUTHORIZATION FOR USE OR DISCLOSURE**

Discover Health Care Participant Name:

**CONSENT TO PHOTOGRAPY; AUTHORIZATION FOR USE AND DISCLOSURE**

I hereby consent to be photographed while participating and/or studying at the hospital or clinic. The term “photograph” includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I hereby authorize the use of the photograph(s) by, or disclosure of the photograph(s) to Adventist Health in the Central Valley.

**PURPOSE**

I hereby authorize the use or disclosure of the photograph(s) for the following uses or purposes:

Allow local and corporate marketing and communication team members to share the photograph(s) for educational, public relations, marketing, news media, and charitable goals. It may be shared with audiences including, but not limited to: Adventist Health employees, providers, volunteers and other internal audiences; and news media, community members and other external audiences. The photograph(s) may be shared through various media, including, but not limited to: newspapers; TV shows; radio stations; internal and external newsletters, websites and magazines; Facebook, Instagram, Snapchat and other social media; billboards; news releases; and other media.

I consent to be photographed and authorize the use or disclosure of such photograph(s) in order to assist educational, public relations, marketing, news media, and charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold the hospital, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

**EXPIRATION**

This Authorization expires 15 years from today. Upon expiration of this Authorization, this hospital will not permit further release of any photograph, but will not be able to call back any photographs or information already released.

**MY RIGHTS**

I may request cessation of filming or recording at any time.

I may rescind this Authorization up until a reasonable time before the photograph is used, but I must do so in writing and submit it to the following address: *Marketing & Communication, 460 N. Greenfield Ave., Ste. 4, Hanford, CA 93230.* I may inspect or obtain a copy of the photograph whose use or disclosure I am authorizing upon request.

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[1](#bookmark0)

I have a right to receive a copy of this Authorization.[2](#bookmark1)

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

I understand that I will not receive any financial compensation.

**SIGNATURE**

Date: Time: AM/PM

Signature:

(c participant/representative/responsible party)

If signed by someone other than participant, indicate relationship:

If translated for the participant, translator print and sign name here:

Print name:

(Healthcare Pathway Program participant/representative/responsible party)

1 If any of the recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan’s eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

2 Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 C.F.R. Section 164.508(d)(1), (e)(2).