CHARITABLE HEALTHCARE NETWORK
Ohio: Stronger. Healthier. Together.

AUTHORIZATION FOR MEDIA AND PUBLICITY USE

I authorize the Charitable Healthcare Network (CHN) and its representatives to:

- Take and use photographs or videos of me/the patient and/or interview me/the patient for purposes including publicity, education, and/or marketing through internal publications, external publications, radio, television, video, social media, or internet platforms.
- Disclose my/the patient's name, contact information, and any statements I/the patient provide to media or news organizations, if applicable, in connection with my/the patient's treatment or experience. I understand this does not include access to my/the patient's medical records, and any further information disclosed by me/the patient to external organizations may no longer be protected under privacy regulations.
- Share my/the patient's photographs, videos, or statements with external partners, including public relations or advertising agencies, who are assisting CHN in its publicity, education, or marketing efforts.

Such photographs, videos, and/or interview content may reveal that I/the patient received care from CHN and may include other personal or health information that I voluntarily disclose.

I understand that:

1. Signing this authorization is not required to receive treatment or payment for care.
2. This authorization only covers the specific photographs, videos, interviews or information I voluntarily provide. It does not grant access to my/the patient's medical records.
3. Information disclosed under this authorization may be reused by recipients, including public audiences, journalists, media outlets, and government organizations. Once shared externally, such information may no longer be protected by privacy regulations.
4. Neither I nor CHN will receive any direct or indirect compensation for the use of my images, videos, or statements.
5. This authorization will expire once CHN has completed the related publicity, education, and/or marketing activities unless I provide written notification to revoke it earlier.
6. I may revoke this authorization at any time by notifying CHN in writing. Revocation will be effective as of the date notified, except where action has already been taken based on my prior authorization. While CHN will make reasonable efforts to remove content from its systems, it cannot guarantee the removal of materials from external sources.

Patient/Participant Information

- Name: _____
- Email: _____
- Telephone: _____

By signing below, I confirm that I have read and understood this authorization and agree to its terms.

Participant Signature: _____ Date: _____
Printed Name: _____

If the patient/participant is under 18, the signatures of both parents or legal guardians are required unless only one has legal authority:

1. Parent/Legal Guardian Signature: _____ Date: _____
   Printed Name: _____
2. Parent/Legal Guardian Signature: _____ Date: _____
   Printed Name: _____

When completed, this form will be retained by Public Affairs, Marketing, or Communications staff. For photo permissions for non-marketing purposes, contact the CHN Office at info@charitablehealth.org or (614) 914-6458.