CONSENT TO PHOTOGRAPH / RECORD / INTERVIEW AND AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

HM2435

Houston Methodist is pleased when patients are willing to share their stories, experiences, and information about their treatment received and allow the use of this information for communication and education. To ensure Houston Methodist is acting in accordance to your wishes, and using your personal information with your authorization, we ask that you complete this form.

I give Houston Methodist (HM) permission and consent to record my image or voice via photographs, films, audio, video, other recordings, and/or interview me and share details of my HM treatment and experience which may include my name, diagnosis, medical condition, and details of health care as a patient, produced by or on behalf of Houston Methodist. I authorize the use or disclosure of this protected health information for the purpose of:

YES ☐ **Publicity, Advertising, Marketing** (including but not limited to print, internet, social media, radio, television)
NO ☐ **Event/Publication:** ____________________

YES ☐ **Medical education** (including, but not limited to conference, graduate education, and continuing medical education)
NO ☐

YES ☐ **Medical publications and professional trade organizations**
NO ☐

YES ☐ **News and Electronic Media Interviews** for publication (including printed media, radio, television, website, and all types of
NO ☐ social media)

Each box checked "Yes" is a permitted use and disclosure under this agreement ("Permitted Uses and Disclosures")

I agree to (authorize) the distribution and publication of the photographs, films, audio, video and other recordings via print or electronic means including but not limited to Houston Methodist's website, Houston Methodist's publications via print, newspaper, magazines, television, radio, social media, advertisement, and other permitted uses and disclosures. I further authorize any such photographs, films, audio, video, or other recordings to be edited and incorporated into any compilation or copied work as considered necessary or appropriate by Houston Methodist. I waive any right to inspect or approve my voice or images in these works. I understand that my photographs, films, audio, video may exist forever in either a recorded, printed, and/or electronic version or other version as may develop over time and that once it is published or disclosed in any form, it may continue to be used. Information pursuant to this authorization may be subject to re-disclosure by recipient and will no longer be protected by state and federal privacy laws.

This authorization does not expire and continues unless revoked. I understand that I may stop the photography, filming, audio, video, or other recording at anytime during the recording process. If I change my mind about the use or disclosure, **I may revoke or withdraw this authorization at anytime** unless the use or disclosure process has already occurred. I may withdraw this authorization by contacting:

____________________.

I further understand that this consent and authorization is optional and I am not required to sign this for medical treatment or payment. I know that I am not entitled to any compensation as a result of any use of information, and photographic, film, audio, or video material. I understand I will disclose my information to the affiliated representatives as I choose and may be identified in any use of the above materials.

I hold Houston Methodist and its employees, affiliates, and representatives harmless from any and all liability, claims, and damages arising from this interview and any associated audio, video, or other print or recording, used or disclosed as a result. A scan, fax or photocopy of this form is as valid as original. By signing below, I acknowledge that I have read and understand the terms of this authorization and knowingly and voluntarily authorize Houston Methodist to use and disclose my protected health information as described above.

____________________ Printed Name of Patient/ Individual Providing Consent

____________________ Date of Birth

____________________ Printed Name of Qualified Personal Representative (if applicable)

____________________ Authority to Act on Behalf of the Patient/Individual Providing Consent

____________________ Signature of Patient or Qualified Personal Representative

____________________ Date

PATIENT LABEL

Consent/ Authorization

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Health Information Management

*Note: A copy of this signed form must be provided to the patient or patient's representative.