capitalhealth
Minds Advancing Medicine

Authorization for Capture, Use and Disclosure of Patient Image

Volunteer Name:	
Date of Birth:	Phone #:

Home Address: City: State: Zip:

1. **Capture of Images:** Capital Health has requested that I permit it, or the third party identified below to capture my image for publication. I understand that these images will be used as described below, and will be seen by the public. I authorize Capital Health, its agents and/or the third party identified below to capture my image through still or video photography. Images may be captured on any media format including film and/or digital memory.

2. **Third Party Contact Information (as applicable):**

   Name: _____ **Telephone:** _____

   Address _____ **City:** _____ **State:** _____ **Zip:** _____

3. **Use and Disclosure of Captured Images:** I authorize Capital Health, its agents or other third parties described in Section 2, above, to use or disclose images of me in the following ways and for the following purposes: (Check all applicable)

☐	Publication in regional newspapers, magazines, television and radio stations (for example. The Trenton Times, Trentonian, Hometowns, Mercer Business, NJN, WPST)
☐	Publication in national news media (for example Associated Press, NBC News)
☐	Publication in Capital Health newsletters
☐	Publication in Capital Health advertising campaigns, including television commercials, billboards and print advertisements.
☐	Publication on Capital Health's Websites (for example, www.capitalhealth.org)
☐	Other: Capital Health's Facebook (www.facebook.com/caphealth) and Twitter (www.twitter.com/caphealthnj) pages

4. **Term/Expiration:** I understand that by law, I do not have to sign this authorization form and that I choose to do so voluntarily. *I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that once this information is disclosed, it is no longer protected by Federal Privacy Regulations and that the information could be re-disclosed without my permission.* This authorization will automatically expire twenty-four (24) months from the date listed below.

5. **Revocation:** You have the right to revoke the authorization to capture and use your images within a limited period of time. You may do so by speaking directly with the Capital Health Public Relations Department (609) 394-6091. Revocation must be made on or before the START day of Junior Volunteering Program.

Signature of Parent/Guardian	Date

Relationship to Applicant