capitalhealth
Minds Advancing Medicine

Authorization for Capture, Use and Disclosure of Non-Patient Image	Description:
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 and local newspapers, magazines, television and radio stations (for example but not limited to: The Trenton Times, Trentonian, Hometowns, Mercer Business, NJN, WPST)
	Publication in national news media (for example but not limited to: Associated Press, NBC News)
	Publication in Capital Health newsletters and publications, for example but not limited to Real Woman and Thriving
	Publication in Capital Health advertising campaigns, including but not limited to regional and local television commercials, billboards and print advertisements.
	Publication on Capital Health's Websites
	Social media including but not limited to: Facebook, Instagram, Twitter, LinkedIn. *I understand that postings to social media may be made concurrently with the capture of my image.*

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 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, and could be seen by an audience broader than that sought by Capital Health.*

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 our Public Relations Department (609) 394-6091 within 24 hours of signing this release.

Signature of Subject or Subject's Representative Date

_____ _____