DOWNSTATE
HEALTH SCIENCES UNIVERSITY

FOR GENERAL USE
(Not for use by patients or
to release medical information)

GENERAL AUTHORIZATION FOR RELEASE OF IMAGES and INFORMATION TO NEWS MEDIA AND THE GENERAL PUBLIC

(Media Authorization Form)

Participant Name: _____

Address: _____

_____

Telephone #: _____ (Day) _____ (Eve) DOB:_____

(only if a minor)

I authorize that a statement/interview, and/or photograph, and/or illustration, and/or video, and/or movie, and/or audio recording may be taken of me and/or my child by SUNY Downstate Health Sciences University (and/or its agents) or by members of the news media regarding my personal information and/or image to publicize, promote, marketing, or advertising SUNY Downstate Health Sciences University's activities, programs, and services.

I grant permission for the above-described material(s) to be used by news media, including professional medical or healthcare journals, for publication, and/or broadcast, and/or distribution via other means to the general public, including the Internet, social media, and mobile telephone applications or future technologies, not excluding its use at professional meetings, symposiums, poster sessions, or other events. As mentioned earlier, I recognize that the precise manner in which the information and material(s) may be used will be determined solely by the media. I, therefore, acknowledge that SUNY Downstate Health Sciences University has no control over or responsibility for the use of such information and material(s).

I further grant SUNY Downstate permission to use the information and material(s) as it sees fit in publications and or productions of its own making and distribution, including on the SUNY Downstate website (www.downstate.edu) and digital monitors throughout SUNY Downstate facilities.

Person(s)/ Organizations at SUNY Downstate providing the information:

_____

If applicable, describe or identify the event where the image was taken:

_____

The information may be disclosed to and used by the (*name of media outlet/s*) (if known)

_____

Information to be disclosed:

_____

I understand that I/my child may be identified by name in connection with the public use of the information and material(s).

I hereby agree to indemnify SUNY Downstate and its affiliates, successors, assignees, and their respective employees, trustees, and agents from and against any and all liability, including reasonable attorneys' fees, arising out of the exercise of the rights granted by this authorization.

I understand that SUNY Downstate ___will ___will not receive direct or indirect remuneration as a result of this authorization.

This authorization expires on_____20_____._____

I understand that the expiration of this authorization will not cause the aforesaid news coverage or promotional, marketing, or advertising materials made as a result of this authorization to be withdrawn from public circulation at the time of expiration or any time thereafter.

You have the right to revoke this authorization at any time, except to the extent that action has already been taken based upon your approval. To revoke this authorization, please write to:

SUNY Downstate Health Sciences University
Office of Communications & Marketing
450 Clarkson Ave., Brooklyn, NY 11203

Signature:_____Date: _____
(Participant, Personal Representative or Legal Guardian)

Personal Representative or Legal Guardian: [Print name] _____

Relationship to the Subject (if not self): _____

Telephone: _____

Email: _____

Address: _____

<u>This form does NOT authorize the release of personal health information</u>. <u>If the participant wishes to disclose personal health information, a HIPAA compliant form must be used.</u>