This portion should be completed by the Children's employee facilitating consent.

Employee name and department:
Event and location:
Patient description:

CONSENT FORM AND WAIVER (PATIENT & FAMILY)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH AND OTHER PERSONAL INFORMATION AND/OR PUBLIC USE OF IMAGE (PHOTOGRAPH OR VIDEO) FORMARKETING PROMOTION, MEDIA AND PUBLIC RELATIONS PURPOSES

I hereby give consent to Children's Healthcare of Atlanta Inc. (hereinafter "Children's"), its affiliates, media outlets, community organizations, and/or third parties providing service to Children's to take and use images (photographs or video) or sounds recordings of me and/or the minor patient/person named below for whom I am giving consent (hereinafter the "Patient"), and to disclose such information in any Children's and/or third party media outlet, including radio, television, internet, social media, or print. I understand that the intended use of such images and information may be for advertising, marketing, fundraising or promotional purposes of Children's.

I understand that the information to be disclosed may include protected health information about the Patient's treatment at Children's obtained from interviews of the family, physicians and hospital personnel, or from the patient's medical records. I hereby waive the right to or interest in the confidentiality of this information or images taken and disclosed to the public, as contemplated in this release. I understand that the information disclosed pursuant to this release may be re-disclosed and no is longer protected by any federal or state privacy regulations.

I acknowledge that this consent and authorization for release of confidential information is being made solely for the benefit of Children's and without any expectation of compensation or other benefit to the Patient or the family thereof. While unlikely, Children's may receive direct or indirect remuneration from a third party. To the extent that any benefit accrues or might accrue to Children's from the use of images or disclosure of information, I hereby and forever waive any interest in or claim to such benefits.

I hereby release and forever discharge Children's (including without limitation all corporate affiliates and officers, directors, trustees, employees, medical staff members and agents) from any and all claims, liability, actions, suits, demands, costs, expenses or indebtedness arising out of, related to, or in any way connected with the use of images or disclosure of the information and materials described herein, and I hereby waive all rights and interest in and to such information and materials.

I understand that I may refuse to sign this authorization, that it is strictly voluntary and that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this release. I have been informed that this authorization is voluntary and is subject to revocation at any time, except to the extent that action has been taken in reliance thereon, by notifying Children's in writing at mediaconsents@choa.org.

Expiration:

- ○ Authorization is ongoing until Patient reaches age of majority (18 years) unless otherwise revoked.

_____
Date

_____ _____
Patient name or name of minor (please print) Patient or minor date of birth

_____ _____
Name of parent/legal guardian/Patient if 18 or older Relationship to Patient

_____ _____
Signature of parent/legal guardian/Patient if 18 or older Phone number

_____ _____
ZIP code Email address

*Completed paper forms must be inputted into online consent portal at choa.org/consent by a Children's employee **within 24 hours**. Paper forms should be hand-delivered or sent via interoffice mail addressed to Public Relations Team at 1575 Northeast Expressway, Atlanta, GA 30329 **within three business days**.