Authorization To Be Audio/Visually Recorded

Patient Name (Please Print)		Date of Birth
Address		Telephone Number
City	State	Zip

1. Permission

I, _____, hereby give my consent to the taking or making of photographs, audio recordings, video recordings, films, quotations and/or media interviews of me or the above-named individual ("Recordings") by a North Shore-Long Island Jewish Health System ("NS-LIJ") personnel or contractors, news media organizations, or any other person or entity that may be designated or authorized by NS-LIJ, for the purpose of creating educational, clinical, scientific, informational, advertising, promotional and/or medical materials.

2. Permitted Uses

I have freely consented to the use of such Recordings by NS-LIJ personnel or contractors, or any other person or entity that may be designated or authorized by NS-LIJ in any manner such parties desire with respect to all of the uses and disclosures described below which I have checked, editing these Recordings at their discretion, using and licensing others to use such Recordings in any manner of media whatsoever and incorporating these recordings into film or video productions or otherwise.

If authorizing all uses and disclosures described immediately below, please check here:

___ All purposes specified below

If you wish to only authorize specific uses and disclosures, please check off all that apply:

___ Advertising
___ Brochures
___ Release to news media
___ Internet (YouTube, Facebook, etc.)
___ NS-LIJ Health System websites and Intranet
___ Other (please explain): _____
___ Education, instructional or teaching purposes
___ Newsletters and Publicity
___ Fundraising publications
___ Commercial Television
___ Research

3. Identification

I understand, agree and consent that I, or the above-named individual, may be identified by name or other identifying characteristic in connection with any public use of this material.

4. Release from Liability

I do hereby release and hold harmless NS-LIJ, its affiliated health care providers, Hofstra North Shore-LIJ School of Medicine and each of their respective governing bodies, officers, agents, appointees, students, employees, and medical and nursing staff from any and all responsibility or for liability resulting from the taking or making of Recordings of me or the above-named individual by NS-LIJ personnel or contractors, news media organizations, or any person, firm or organization that may be designated or authorized by NS-LIJ, and any resulting release of private and personal medical, mental health and social information concerning me or the above-named individual and respective families. NS-LIJ and its affiliated health care providers are not responsible for the release by third parties to whom it discloses information pursuant to this authorization.

5. Waiver of Royalties

I do hereby waive any and all rights I or the above-named individual may have to Recordings and royalties or other compensation in connection with the publication or other use of Recordings. I further acknowledge that there were no promises of any compensation for such use by NS-LIJ and that NS-LIJ exclusively owns all rights to these Recordings irrespective of the form in which they are produced and used.

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6. Expiration Date or Event

This authorization will expire on (please check one and complete as applicable):

☐ When all NS-LIJ programs or initiatives involving the permitted use(s) specified in Section 2 are terminated.
☐ One (1) Year
☐ Other (please specify expiration date) _____

7. Revocation

I understand that I have the right to revoke this authorization at any time, except to the extent that NS-LIJ or others have already taken action based upon the authorization. I hereby acknowledge that my revocation of this authorization will not prohibit the further disclosure of any Recordings by third parties who will have already received them based on this authorization. To revoke this authorization, please write to the **North Shore-Long Island Jewish Health System Department of Corporate Communications, 125 Community Drive, Great Neck, NY 11021.**

8. Voluntary Nature of Authorization

I understand this authorization is voluntary. Neither NS-LIJ nor any health care providers with whom it is affiliated will condition medical treatment or other benefits on my willingness to sign this authorization.

9. Redisclosure

I understand that persons or entities that receive Recordings under this authorization from NS-LIJ may not be restricted from re-disclosing such Recordings under applicable law.

10. Signature

By signing below, I acknowledge that I have read and accept all of the above.

_____
Sign Name of Patient or Personal Representative (*individual authorized to consent to the use or disclosure of information)* [Note: If the subject of the Recordings is a minor (under 18 years of age), the consent of a parent or legal guardian must be obtained.]

_____
Print Name of Patient or Personal Representative (*individual authorized to consent to the use or disclosure of information)*

_____
Relationship to Individual

_____
Date

IF ANY HIV, GENETIC INFORMATION OR MENTAL HEALTH INFORMATION MAY BE INCLUDED IN ANY RECORDING MADE UNDER THIS AUTHORIZATION, THE INDIVIDUAL OR HIS OR HER PERSONAL REPRESENTATIVE MUST ALSO SIGN THE GENERAL NS-LIJ AUTHORIZATION FORM AND MUST SPECIFICALLY AUTHORIZE THE USE/DISCLOSURE OF SUCH INFORMATION.

THE INDIVIDUAL OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED. IF MAILING IN THE FORM, PLEASE RETAIN A COPY.

[For internal use only] Event/Purpose/Story: _____]