AUTHORIZATION FOR PHOTO/INTERVIEW RELEASE

Name: (print name)	Age:	Address: Street: ______________________________
Telephone Number:	Birth Date:	City: ______________________________ State: Zip:

1) I hereby authorize St. John Health, and its affliates/contractors and agents to photograph, interview, use and publish my photographic or video image or the photographic or video image of my minor child(ren)___________________________ (Name of Child or Children) or property.

2) I understand that the photographic or video image may be produced and released in any media form, including but not limited to internet, newspaper, television, radio and or marketing materials in whole or in part, with such alterations and changes as St. John Health desires, and that the images may appear separately or with my name or name(s) of my minor child(ren) included in the release.

3) I understand that the purpose of the use or release of the photographic or video images and media interview will be for education, marketing or public relations purposes. Uses shall include ____________________________.

4) The use or release of the images will be made either to the public through marketing/public relations efforts for commercial or noncommercial publications, exhibits, intranet and internet.

5) I agree that all pictures, reproductions, negatives and tapes on any kind relating to the images are and shall remain the property of St. John Health and its agents to whom permission has been granted.

6) I understand that this Authorization for Release of information/images can be revoked by me at any time by submitting a written request to SJH Marketing and Public Relations at VP Marketing, SJH 28000 Dequindre.

7) I understand that revocation will not apply in those instances in which St. John Health has acted upon this Authorization prior to the revocation being received by St. John Health including reasonable time to action same.

8) I understand that the information released pursuant to this Authorization may be subject to redisclosure and no longer protected by state and federal privacy laws.

9) I understand that St. John Health cannot require me to sign this Authorization as a condition of providing treatment to me or my minor children or obtaining payment for treatment.

10) This Authorization will expire:_________________. [Insert date or event of expiration].

I have read and had the opportunity to have my questions answered and understand the above terms and conditions and hereby authorize St. John Health and its affiliates, agents and contractors to photograph, interview, videotape and publish named image as described in this release.

Patient Signature/Authorized Representative:	Date Signed:
Relationship:	Witness:

A copy of this Authorization must be presented to the person signing the Authorization.