____ **(Initial)** I authorize and grant permission to Texas Scottish Rite Hospital for Children (TSRHC), its staff, and its outside media representatives to photograph, video record, audio record, and interview me/my child/my ward.

____ **(Initial)** I further authorize and grant permission to TSRHC to copyright, use, and publish the photographs/video recordings/audio recordings, along with the name, age, city of residence, and personal story of me/my child/my ward, all or some of which may include health information, to increase public awareness of the hospital and its patients, and for other hospital-related purposes/programs. I also authorize and agree that, for the purpose of increasing public awareness of the hospital and its patients, and for other hospital-related purposes/programs, such photographs/video recordings/audio recordings, along with the name, age, city of residence, and personal story of me/my child/my ward, all or some of which may include health information, may be (1) published in newspapers, magazines, journals, textbooks, and other printed materials; (2) distributed to the press; (3) broadcasted on radio and television; (4) shared with outside entities/individuals associated with hospital-related purposes/programs; and (5) included in videos, audio recordings, websites, social media, and presentations.

If I/my child/my ward am/is a hospital patient:

I understand that this authorization is voluntary and will expire the day after TSRHC permanently ceases to distribute information to the public about the Hospital, its patients, and its purposes/programs, whenever that occurs. I understand that photographs/video recordings/audio recordings and information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and are no longer protected information. Such redisclosure by the recipient may include, but is not limited to, redisclosure via videos, audio recordings, websites, social media, and presentations.

I understand that I have the right to revoke this authorization at any time provided that it is in writing, except to the extent that TSRHC has taken action in reliance thereon. To revoke this authorization, I understand that I should send my revocation in writing to HIPAA Privacy Officer, Texas Scottish Rite Hospital for Children, 2222 Welborn Street, Dallas, Texas 75219, or by email at privacyofficer@tsrh.org.

I understand that TSRHC may not and will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

				☐ Yes ☐ No
Name of Child	Age	Date of Birth	City of Residence	TSRHC Patient

Authorization Signature	Date	Relationship to Child

Originating Event Title:

S-270
2/2015