Each adult attendee (excluding children’s hospital staff) must complete this form. Parents must complete this form on behalf of their children (under the age of 18 years).

I, ____________________________ (parents/guardians and all children, including siblings, even if not participating in media coverage must be included)

(each a “Participant”), for good and valuable consideration, the receipt and sufficiency of which is acknowledged by the parties for the rights granted in this Publicity Release (“Release”), for myself and on behalf of my heirs and representatives, hereby irrevocably authorize and consent to, and grant to, National Association of Children’s Hospitals, National Association of Children’s Hospitals and Related Institutions and Child Health Corporation of America (also known as the Children’s Hospital Association together, the “Association”) the unrestricted and transferable right to (and to authorize others to):

1. Record, film and photograph via audio, video or other media (picture and sound) my name, voice, picture, image, performance or other likeness of me (“Images”) and my statements and quotes, whether provided orally or in writing (“Statements”) (collectively referred to as “Released Materials”), and to edit, modify or paraphrase the Images and Statements; and

2. Use, reproduce, publish, display, publicly perform, license, sell, distribute and otherwise exploit (in any and all media and formats, whether now known or hereafter developed) worldwide in perpetuity the Released Materials, individually or in combination with other images, text or printed materials, for purposes of advertising, educational materials, public relations, marketing, promotion display materials, and publications of Association, its affiliates and promotional partners, and their respective products and services (collectively, the “Work”).

I understand that Association is and will be the sole and exclusive owner of all rights in the Released Materials and Work, including, without limitation, all photographs, films, slides and negatives, video and audio tapes or electronic files, and other recordings. I irrevocably convey, transfer, and assign to Association all my worldwide rights of any kind and nature in the Released Materials and Work in perpetuity. Association has the right to copyright and otherwise secure proprietary rights in the Works, without limitation or reservation. I hereby waive any right I may have to inspect or approve any Work or use of the Released Materials by Association, its agents, successors, assigns, or licensees. I hereby waive any and all moral rights in the Work (to the extent any moral rights exist).

I represent that all Statements and information I provide about myself are true and accurate and reflect my true and honest opinion and expression of my personal experience regarding Association, its products and services.

I understand that I shall not receive any compensation for the rights granted under this Release. I understand that Association has no obligation to make any use of the rights granted in this Release or to provide any acknowledgement to me.

I hereby and forever, irrevocably and unconditionally release and discharge Association, its affiliates and related companies, and their past and present directors, officers, trustees, employees, and agents, and their successors, and assigns, from all claims, demands, complaints or causes of action of any kind, relating to or arising from the Released Materials, the Work or any use thereof as provided in this Release, including all claims for libel, defamation, false light, invasion of privacy, or violation or misappropriation of personal rights. This Release specifically includes all claims in tort or contract, and all claims seeking compensatory or punitive damages, consequential, incidental, or indirect damages, attorneys’ fees, costs, injunctive relief, or any other relief whatsoever.

This Release represents the complete agreement and understanding of the parties relative to the Released Materials and Work. There are no understandings, promises, or expectations regarding the use and ownership of the Work that are not expressly set forth in this Release. This Release is not to be construed against or in favor of either party on the basis of draftsmanship.

For Participants under age 18, the following consent of the Participant’s parent or guardian must be completed and signed. All family members participating must be listed. All parents/caregivers participating must sign.

I/we represent that I/we am the parent/guardian(s) of the above named participants. I hereby consent to this Release on behalf of myself/ourselves and all of my/our children.

Signature of Patient (18 or older), Parent, Guardian ____________________________

Printed Name of Signatory ____________________________

Date ____________________________

Printed Participant(s) Full Name(s)

Basis or Personal Representative’s authority to sign for Patient ____________________________

Hospital ____________________________
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION – A parent must complete this form on behalf of each child (under the age of 18 years) who is a children’s hospital patient participating in Family Advocacy Day.

I hereby authorize the Children’s Hospital Association (formally known as the National Association of Children’s Hospitals and Related Institutions, the National Association of Children’s Hospitals and the Children’s Health Corporation of America) and/or any affiliate or related organization, officer, employee, representative, or agent (“Children’s Hospital Association”) to use and disclose to the public certain protected health information (“PHI”), of _____________________________ (“the individual”).

Information to be Used or Disclosed
I authorize Children’s Hospital Association to use and/or disclose certain PHI (as defined by the Health Insurance Portability and Accountability Act (“HIPAA”) and its implementing regulations, 45 C.F.R. Part 164). This PHI consists of the individual’s name, insurance status, medical condition, medical or health history, diagnosis and prognosis, name of treatment facility and/or treating health care providers, treatment of that condition, prescriptions, diagnostic test results, any reports, date of diagnosis and symptoms, hometown city, birth date, Web URLs, audio clips and images of any kind (including, but not limited to, x-rays, video or photographic images, MRIs, and CT scans), and medical expense and billing/payment records and information, as well as any other PHI that I have provided to the Children’s Hospital Association or that has been provided to the Children’s Hospital Association by a member hospital pursuant to authorization provided by or on behalf of the individual. I understand that such “PHI” may include information and records that may be protected under Federal Law (such as regarding mental health, alcohol or drug abuse information) and/or State Law (such as regarding mental health treatment, developmental disabilities, privileged or private communications, communicable or infectious diseases, alcohol/drug abuse, AIDS or HIV).

Person(s) Authorized to Make the Use or Disclosure
I hereby authorize Children’s Hospital Association, including its employees and agents, to make the uses and disclosures specified in this Authorization.

Recipient(s) of Use or Disclosure
The individual’s PHI may be used by or disclosed to the public, including to members of federal or state legislative and executive branches and to the media.

Purpose(s) of the Use of Disclosure
The Children’s Hospital Association, including its employees and agents, may use and disclose the individual’s PHI for the purposes of public advocacy; government (including legislative and administrative) relations, outreach, and advocacy; outreach; public relations; media relations; social media; education; and research.

This Authorization will expire when the Children’s Hospital Association no longer desires or needs to use or disclose the individual’s PHI for the purposes listed above. I understand that I may revoke this Authorization at any time by submitting a written revocation to the Children’s Hospital Association, Attn. External Relations, 600 13th Street, NW, Suite 500, Washington, D.C. 20005. However, such revocation will not be effective with respect to any use or disclosure made by Children’s Hospital Association in reliance on this Authorization before the Association received my revocation.

I understand that I am free to refuse to sign this Authorization without consequence or penalty, and that the Children’s Hospital Association will not use or disclose the individual’s PHI for the purposes listed above without such authorization.

I understand that Children’s Hospital Association does not engage in the marketing or sale of PHI.

I understand that the Children’s Hospital Association is committed to improving the health and well-being of children treated by its member hospitals. I understand, however, that the Children’s Hospital Association is not a covered entity under HIPAA and, except as to certain functions it performs for member hospitals, is not subject to HIPAA and that any PHI provided to the Children’s Hospital Association in connection with this Authorization or other authorizations may not be protected by HIPAA and its implementing regulations. I understand that I am authorizing the Children’s Hospital Association to disclose this information to the public for the purposes listed above. Once the Children’s Hospital Association makes such disclosures, the information will not be considered PHI, can be re-disclosed by the people who received the PHI, and will not be protected by HIPAA and its implementing regulations (45 C.F.R. Part 164).
I understand that I have the right to request and receive a copy of this Authorization. I understand that I may inspect the disclosed information upon written request. A copy of this Authorization, including an electronic copy, or an electronic Authorization, shall be valid and is to be accepted with the same effect as the original or as if physically signed by me.

I confirm that I am the individual identified above, or that, to the best of my knowledge, I am the personal representative of the individual or am otherwise legally authorized to represent the interests of the individual.

Signature of Patient (18 or older), Parent, or Guardian       Date

Printed Name of Signatory

Patient’s Full Name

Basis of Personal Representative’s authority to sign for Patient

Hospital

THIS AUTHORIZATION IS NOT VALID UNLESS SIGNED AND DATED. IF THE INDIVIDUAL IS AN EMANCIPATED MINOR OR 18 YEARS OLD OR OLDER, THE INDIVIDUAL MUST SIGN THIS AUTHORIZATION. THE CHILDREN’S HOSPITAL ASSOCIATION WILL NOT CONDITION TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS ON YOUR SIGNING OF THIS AUTHORIZATION. A COPY OF THIS AUTHORIZATION MUST BE PROVIDED TO THE INDIVIDUAL COMPLETING THIS FORM.