Topic: _____ Photo/video taken: ☐ yes ☐ no Release #_____

CONSENT to be in SSM Health News Stories, Educational Materials or Promotions

I consent to be:

☐ Photographed or videotaped
☐ Interviewed
☐ Identified by name
☐ Other:_____
☐ All of the above

I consent to be included in the following:

☐ Public news media (including print, such as newspapers/magazines, and/or broadcast, including TV/radio/Internet)
☐ SSM Health marketing, public relations and educational materials
☐ Social media sites (including SSM Health websites, Facebook, Twitter, blogs, and/or Flickr)
☐ Archives and historical displays
☐ Other: _____
☐ All of the above

EXCLUSIONS

The undersigned agrees that SSM Health may use and permit other persons to use the consented materials for purposes including, but not limited to, dissemination to hospital staff, physicians, health professionals and members of the public for educational and marketing purposes. Such use is subject only to the following limitations (list, if any):

_____

I understand that:

1. My participation is strictly voluntary. If I do not sign this form, my health care and the payment for my health care will not be affected.
2. I will receive no compensation for my participation.
3. This consent form will expire in 100 years and the materials may be retained indefinitely.
4. I have a right to withdraw my consent at any time by contacting Public Relations & Marketing, until a reasonable time before the materials are used.
5. By signing this form, the personal health care information I relay to an outside source is no longer protected by state and federal privacy laws and may be re-disclosed by that source.
6. I will be given a copy of this form after I sign it.

I understand that, in the instance of outside sources (such as the news media), SSM Health is acting only as the intermediary, making it possible for the aforementioned source(s) to contact me. I agree to hold SSM Health and its members, directors, officers and employees harmless from any and all liability arising out of the use and/or release of information, interview, photograph/videotape/film, and subsequent publication or broadcast.

Signature of patient/subject and/or guardian:	If guardian signed, relationship to patient/subject:
Print Name of Patient/Subject:	Date
Street Address	City/State/Zip Code
Best way to contact you in case of questions (email and/or phone):	

OFFICE USE ONLY

Description of consent-giver (if photographed): _____

Names/descriptions of others in photo:_____

☐ Copy placed in medical record, if subject is a patient. (Not required.)

Updated November 2014