Children's Hospital of Wisconsin

Authorization to release images/protected health information for public relations and marketing

1. I hereby authorize Children's Hospital of Wisconsin to take and/or disclose protected health information (PHI) or other media on:

Patient/child name: _____ Date of birth: XX/XX/XX

Address: N/A Telephone: (XXX)XXX-XXXX

City: Milwaukee State: WI ZIP: 53201

Covering the period(s) of health care: from (date) ____/____/____ to (date) ____/____/____ ☒ Ongoing

2. Type of information to be taken and/or disclosed:

☐ Release of one-word condition reports and discharge.

☒ Photographs, video, digital, scans or other images. Description: Group Picture

☐ Patient/parent/physician/staff interview with news media, including newspapers, magazines, wire services, television, radio or Internet.

☒ Other (please specify) _____

3. Information is to be disclosed to Emailed and Posted in Department for the purpose of Identification

4. PHI delivery options: ☐ Email ☐ Telephone ☐ In person ☒ Other (specify) N/A

5. This authorization is valid until the following date(s)/event: ____/____/____. If no date is specified, this authorization will expire one (1) year from the date signed.

6. I agree that all reproductions and all copyrights associated with the above described information and media are and shall remain the property of Children's Hospital of Wisconsin, its successors and/or assigns. I agree not to request or accept any payment or other consideration in exchange for signing this agreement and for the use of any of the above photography or media materials.

7. PROHIBITION ON RE-DISCLOSURE: Federal and Wisconsin confidentiality laws protect this information.

However, I understand that the information disclosed may be potentially redisclosed by the recipient and may no longer be protected by the federal privacy and confidentiality rules. I have had an opportunity to review this and understand the content of this authorization. I understand that this authorization is voluntary. Children's Hospital of Wisconsin will not condition my or my child's treatment, payment and enrollment in a health plan or eligibility for health care benefits based on my decision to sign this authorization. I understand that I have the right to revoke this authorization any time. I can do so by submitting my revocation in writing to the Public Relations and Marketing Department. I understand that my revocation will not apply to information that already has been released in response to this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes.

8. Authorizing signature: _____ Email: _____

Relationship to individual: ☐ Parent ☐ Guardian ☒ Self ☐ Legal representative authorized by the patient 18 years or older.

Name: _____ Date: ____/____/____
(Please print)

Children's Hospital of Wisconsin representative: _____ Date: ____/____/____

Return to Children's Hospital of Wisconsin Public Relations and Marketing.

Fax: (414) 266-5439 or send to PO Box 1997, MS C610, Milwaukee, WI 53201-1997.