

Southeast Georgia Health System

CONSENT TO RELEASE INFORMATION AND AUTHORIZATION FOR USE OR DISCLOSURE

Southeast Georgia Health System is committed to educating and informing the public and other healthcare providers about medical treatments and innovations. One of the most effective ways to share news is through patient, physician and team member stories. Thank you for agreeing to participate in these efforts. This form ensures that you understand how your information will be used and that you agree to its release.

The information that will be released is: _____

News media or organizations to which the information will be released are: _____

I (name) _____ understand that news media organizations are not covered by federal privacy regulations and that the information described above, once released; may become available for use by the media at any time in the future.

I understand that any interviews, photograph, movie, video or audiotape taken will become and remain the sole property of Southeast Georgia Health System or of the authorized media organization named above. I agree that the interview, negatives, prints, videotapes, audiotapes or computer graphics prepared therefore may be used for any purpose, including medical research, professional or patient education, brochures, newspapers, magazines, Web sites, television, billboards, exhibits, audiovisual or multimedia presentations, kiosk imaging, radio broadcasts, and any other news, public service, promotional or advertisement reason.

This authorization will expire: ____/____/____ (one year from date of event)

I understand that I may cancel this authorization prior to its expiration to prevent the additional release of information and/or any photography, movie, video or audiotape. Cancellation requests must be sent in writing to the Southeast Georgia Health System, Attention: Marketing Department, 2415 Parkwood Drive, Brunswick, GA 31520 to which this authorization pertains.

I understand that I am not required to participate in media projects and that my decision to take part or not take part will not change the provision of healthcare available from Southeast Georgia Health System.

I understand I have a right to receive a copy of this Authorization.

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I hereby approve the release of my information for the purposes described on page one.

Name (Please Print)	Signature	Date
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Parent/Guardian/ Patient Representative's Name If applicable (Please Print)	Signature	Date
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If signed by someone other than the patient, state name and legal relationship:

Name	Explanation of legal relationship
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Telephone Number	Patient's Date of Service	Patient's Date of Birth
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Street Address

City/State/Zip Code

System Representative (Please Print)	Signature	Date
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