**Name:** ______________________________

**Address:** ______________________________

**City, State, Zip:** ______________________________

**Phone Number:** ______________________________

**Email:** ______________________________

**Authorization for Publicity and Photographs**

I consent to provide information, be interviewed and/or to have photographs or video images taken of me while I am in a Bayhealth Medical Center facility or attending a Bayhealth Medical Center event.

**Information to be Released:**

______________________________________________________________________

(i.e. statement, interview, photograph(s))

**This information may be released to:**

- ☐ The news media
- ☐ Employees, agents or subcontractors of Bayhealth Medical Center involved in the preparation of public relations or educational materials.
- ☐ Bayhealth Social Media

**Purpose of Disclosure:**
The information may be used or disclosed in order to provide information to members of the news media, or in the preparation of advertising or educational materials, brochures, newsletters, or for other public relations purposes.

I hereby release Bayhealth Medical Center, and any of its agents or personnel, or any other persons participating in my care from any and all liability which may or could arise from the taking or the use of such materials.

1. I understand that I may revoke this authorization at any time by notifying the Bayhealth Privacy Coordinator in writing at 640 S. State Street, Dover, DE 19901. I understand that revocation will not have any effect on actions Bayhealth took before they received the revocation.
2. This authorization is voluntary. I understand that my treatment or payment for services will not be affected if I do not sign this authorization.
3. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations.

Signature: ______________________________________________Date: ______________

Signature of Parent/Guardian if individual is a minor/ incompetent:

________________________________________________________Date: ____________

Hospital Representative: ____________________________________________________