This release gives CHRISTUS permission to photograph and/or video the individuals named below and in the attached for promotion of CHRISTUS Health and CMNH.

Testimonial Release Form

By signing below, I authorize CHRISTUS Shreveport-Bossier Health System to distribute, publish, reproduce, edit, exhibit, and display, through any form of media (print, digital, electronic, social, broadcast or otherwise), the following: (i) my name, gender and age; (ii) any written testimony or the product of any interview that I have given to CHRISTUS or its agent, including information about my medical condition or treatment; and (iii) images of me, including video and audio recordings, that have been taken or recorded at the request of CHRISTUS for non-treatment-related purposes or that I have provided to CHRISTUS (collectively, the “Materials”).

I understand and agree that these Materials will become property of CHRISTUS and will be used for publication, promotional or educational purposes. I further understand and agree that I will not receive payment or other consideration for the Materials or their use.

CHRISTUS agrees not to sell or otherwise distribute the Materials for use by a third party unrelated to the promotional or educational purposes of CHRISTUS. I understand, however, that once the Materials have been published, a third party may gain access, republish or use the Materials without seeking my permission.

I agree to hold harmless and forever release CHRISTUS, its officers, representatives, employees, and agents, from any liability connected with or arising out of the use of the Materials.

I may revoke (take back) this release by sending a letter that includes my name and address and identifies my Materials to the CHRISTUS Privacy Officer. However, I understand that revoking the release will not affect any use of the Materials made before my revocation is received and processed, including any printed publications or displays in process at the time of revocation.

I certify that I am at least 18 years of age and am competent to contract in my own name. I have read and understood the contents of this release, and I sign below voluntarily.

Signature: ____

Printed Name: _____________________________________

Date: ________________________

Relationship to Patient (if not patient): ____

Phone Number: _____________________ Email Address: _____________________________

Witness Signature: __________________________________

Printed Name: ______________________________________

Date: ________________________

Authorization for Use and Disclosure of Protected Health Information for Marketing Purposes

Patient Identification

Printed Name: ____ Date of Birth: ___________________________

Address: ____

____

~~Social Security #:~~ ______________________________________ Telephone: ____

Information To Be Released – Covering the Periods of Health Care

From (date) ____n/a______________________________________ To (date) _______ n/a ______________________________________

Please check type of information to be released:

~~☐ Complete health record~~	☐ Diagnosis & treatment codes	~~☐ Discharge summary~~
~~☐ History and physical exam~~	~~☐ Consultation reports~~	~~☐ Progress notes~~
~~☐ Laboratory test results~~	~~☐ X-ray reports~~	~~☐ X-ray films / images~~
☐ Photographs, videotapes	~~☐ Complete billing record~~	~~☐ Itemized bill~~

☐ Other, (specify) ____

Purpose of Request

Marketing purposes as described here: _For use by CHRISTUS Health, CHRISTUS Shreveport-Bossier Health System and Children's Miracle Network Hospitals for promotion of CMN Hospital programs on television, web, social media, and in print_____________

Payments to Facility

This marketing activity involves direct or indirect compensation/payment from a third party to ***Name of Facility*** for this use of protected health information. ***Check One*:** ☐ **Yes** ☒ **No**

Who and Where to Send / Release Information

Name: ________n/a____

Address: ________n/a____

____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I have been afforded the opportunity to sign a specific authorization.

***Initial One: Yes*_______ No________ Not Applicable __☒ _____**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I have been afforded the opportunity to sign a specific authorization.

***Initial One: Yes*_______ No________ Not Applicable __☒ _____**

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Janelle Thoms (318) 561-4134. Unless revoked, this authorization will expire on the following date or event ____, or 180 days from date of signature, unless otherwise specified.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. I can inspect or copy the protected health information to be used or disclosed. **I authorize CHRISTUS Shreveport-Bossier Health System to use and disclose the protected health information specified above.**

Signature: ____ Date: _______________________

Authority to Sign, if not patient: ____

Identity of Requestor Verified via**:** ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** ___________________________

Authorization for Use and Disclosure of Protected Health Information for Marketing Purposes

Name:	Signature:

Authorization for Use and Disclosure of Protected Health Information for Marketing Purposes

Name:	**Signature:**