Authorization to Use and Disclose Images, Voice Recordings and/or Testimonials

I, _____, authorize the Health Care District of Palm Beach County, its assignees, licensees, designees, representatives, agents and affiliated entities including, but not limited to Lakeside Medical Center, Edward J. Healey Rehabilitation and Nursing Center, C.L Brumback Primary Care Clinics, School Health, Pharmacy, Aeromedical, Ground Transportation, or program not listed, collectively known as "District", to use and disclose information about me, including my protected health information, for use in internal publications and to the general public or media. The information that will be used and/or disclosed about me may include the following: *Check all that apply*

☐ All ☐ Name ☐ Diagnosis/Condition/Treatment ☐ Services Provided ☐ Treating Provider/Specialty

☐ Treatment Location ☐ Photographs/Digital Images ☐ Video/Audio Clip(s) ☐ Personal Story/Testimonial

☐ Medical Image and Voice Recordings ☐ Artwork ☐ Other_____

The information above may also be disclosed to external media in the following but not limited forms: press releases, stories, photographs or video clips. It may also be used for internal purposes or on the District's website or through the District's own marketing or educational campaigns. I authorize the District to use, reuse, copy, publish, display, exhibit, reproduce, license to third parties, and distribute the materials in any educational or promotional materials or other forms of media, which may include, but are not limited to articles, magazines, advertisements, recruiting brochures, websites or publications, electronic or otherwise, without notifying me. I understand that neither I, nor the District, will be compensated in any way for the taking or use of my information, photographs, films, audio, and/or video.

I understand that the Health Care District will not condition treatment on my provision of this authorization. I understand that any information used or disclosed pursuant to this authorization is no longer protected and may be re-disclosed. Such authorization will remain effective for a period of 99 years.

I hereby allow the District to use my identifying information described above for:

☐ Use in any District publications, advertisements, social media platform and/or external media release

☐ ***Only*** for the following use: _____

_____ _____
Signature of Individual/Patient/Resident Date of Birth

_____ _____
Name of Legal Guardian/Personal Representative Date

_____
Legal Relationship

This authorization may be revoked in writing by sending a written request to the address listed below:

Health Care District of Palm Beach County
Attn: Communications Department
1515 N. Flagler Drive, Suite 101 West Palm Beach, FL 33401-3429