I hereby grant permission to AtlantiCare, its employees and assigns and/or outside media to photograph, videotape or interview me and/or my dependent(s) on this date _____. The specific information AtlantiCare can releases to traditional and new media and through other AtlantiCare communications channels includes:

Photos/Video Story/Testimonial Interview Other, describe:

_____

_____

I understand that the photographs, video, audio, or interview shall become the property of AtlantiCare and/or outside media and organizations and that I shall not have any rights to the same. I also understand that I will not be compensated for participating in the taking of photographs; video, audio and other recordings; or interviewing and that I will not be entitled to compensation as a result of the broadcast or publication of the information.

I understand that the photographs, video or interview may be used and redisclosed as a press release and shared with media for possible publication or broadcast. I also understand that the photographs; video; audio and other recordings; and/or interview might be publicized or broadcast, or used in promotional and informational materials that include, but are not limited to, brochures, billboards, advertisements, the AtlantiCare Internet and Intranet sites, Facebook and any and all other social media and traditional media and publicity and marketing and communications venues. I understand that the information, photographs, audio, video, and/or interview might be edited and I agree that AtlantiCare, its employees and/or agents shall have the right to, at any time, add to, edit, arrange, rearrange and/or revise such information, photographs, video or interview. I understand that AtlantiCare maintains the right to reuse the information, photograph, video, or interview for future purposes without additional authorization or release.

I release AtlantiCare, its employees and agents from any and all claims and from all liability including, without limitation, claims for libel, invasion of privacy and/or misappropriation of likeness arising out of the interviewing, photographing or videotaping and subsequent publication or broadcasting of this material. I understand that I am not required to sign this authorization and that AtlantiCare will not condition treatment on my execution of this authorization. I understand that I have the right to revoke this authorization at any time prior to AtlantiCare's compliance with the request. The revocation must be in writing and is subject to terms described in AtlantiCare's Notice of Privacy Practices and other AtlantiCare policies.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable state and federal regulations and that the information disclosed by this authorization may be redisclosed by the recipient and will no longer be protected by HIPAA. This authorization will expire 12-31-2120.

Name (please print):_____

Home town:_____

Please circle one:

Employee	Patient	Other Customer

Signature: _____

If Subject is a Minor: Name of Parent or Guardian (please print):_____

Signature: _____

Office Use Only Description:_____

_____

_____