HACKENSACK UNIVERSITY MEDICAL CENTER

30 Prospect Avenue, Hackensack, New Jersey 07601

551-996-2000

Media Consent

Patient Name/Name of Subject: _____

Date of Birth: _____ E-Mail Address: _____

Address: _____

_____

Telephone: _____

Patient Room (if applicable): _____

I hereby authorize Hackensack University Medical Center ("HackensackUMC") to conduct and record an interview and/or make still photographs, motion picture recordings and/or audio recordings of me (collectively "Recordings") for publication in newspapers or other print media, broadcast on radio or television, display and transmission on the internet (including without limit websites, email, social media applications, blogs and other modes of internet communication) or for use in any hospital publication or transmission, photographic display or other hospital use.

I waive any claim that the foregoing Recordings of me constitute protected health information under any state or federal law and expressly authorize HackensackUMC to keep, use, transmit and disclose such Recordings until such time as I send HackensackUMC written notification that I revoke this Media Consent.

This Media Consent is not applicable for disclosure of records containing AIDS or HIV infection, Psychiatric Care or records related to Drug or Alcohol Abuse.

I understand that I may revoke this authorization at any time by sending HackensackUMC a written notice of termination that includes my name, address and date of birth. The notification should be sent to Hackensack University Medical Center, 30 Prospect Avenue, Hackensack, NJ 07601 ATTN: Legal/Regulatory Department. I understand that such a revocation will not apply to Recordings already used, disclosed or transmitted or to extent that action has been taken in reliance on this authorization. Unless revoked earlier, this authorization will expire on the following date, event, or condition: _____n/a_____.

I hereby release and waive any claim that I may have or come to have against Hackensack University Medical Center, its employees, officers, physicians or anyone acting for any of them for acts or omissions that arise out of this Media Consent.

I understand that I am not required to sign this Media Consent in order to receive treatment, payment, enrollment or eligibility for benefits of any kind.

Signature of Patient or Legal Representative Date

Signature of Additional Legal Representative Date

Signature of Witness Date

[note: provide a copy of this signed Media Consent to the Patient/Legal Representative]