Authorization for Use/Release of Information/Photography

_____ _____ (_____) _____-_____

First and Last Name, *please print* Birthdate Phone Number

1. I permit any authorized representative or agent of Trinity Health, its affiliates, and its photo and video storage vendor, Canto, Inc. (625 Market St #600, San Francisco, CA 94105) to use and disclose my identity and protected health information (PHI) if applicable, including interviews, images, quotes, comments and videos internally, for educational or business purposes, and/or externally, for advertising, marketing, social media, public relations, public affairs or similar activities.
2. I understand that other individuals, organizations, or businesses may receive my information either directly or indirectly and that they may share it with their own audiences. I further understand that Trinity Health and its affiliates have no control over such reuse of my information. Recipients may include:
   - Public audiences
   - Journalists, media outlets and/or their representatives
   - Other health care and/or government organizations
   - Local, state and/or federal policymakers
   - Researchers and/or educators
3. I understand that I will not be compensated in any way for participating in this agreement or for the use of my image, quotes, comments or information.
4. I authorize the storage by Trinity Health and/or Canto, the storage vendor of the information described above — for two years from the date signed.
5. I understand that I can cancel this authorization in writing, or in person, any time and that the cancellation will prevent all future disclosures by Canto, Trinity Health and/or its ministries. I can cancel my authorization at any time by calling the department holding the signed documents and verifying my identity, but I understand this request is only legally binding if I cancel my authorization by mailing, faxing, or taking a letter and proof of my identity in person to the ministry that initiated this authorization. I also understand that a representative of Trinity Health or one of its affiliates will contact me to authorize any other or further uses of my information.
6. I understand that neither Trinity Health nor any of its affiliates can require me to sign this authorization as a condition of getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan.

_____ _____

Signature Date

TO BE FILLED OUT BY TRINITY HEALTH/RHM STAFF

_____ _____ _____

Witness Name and Title *please print* Witness Signature Date

_____ and/or _____ _____

Colleague ID Number (if applicable) Street Address City/State/Zip

_____

Project Name

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