MEMORIAL HERMANN HEALTHCARE SYSTEM
MEMORIAL HERMANN HOSPITAL SYSTEM
PHOTOGRAPHIC OR RECORDING CONSENT, RELEASE AND WAIVER

I, _____ (print full name), consent to photographs or recordings of me as described below (see section 1), and **irrevocably grant*** to Memorial Hermann Healthcare System/Memorial Hermann Hospital System, their affiliates, nominees, licensees, successors and assignees, and those acting with its permission or authority (hereinafter collectively referred to as "MH"), with respect to the photographs, film, audio, electronic media or tape taken of me by, or on behalf of MH, (the "Pictures or Works"), the unrestricted absolute, perpetual, worldwide right to:

(1) create the Pictures or Works for the following specific circumstance: _____; and,

(2) reproduce, copy, modify, create derivatives in whole or in part, or otherwise use the Pictures or Works, or any part thereof in combination with or as a composite of other matter, including, but not limited to, text, data, images, photographs, illustrations, animation and graphics, video or audio segments of any nature, in any media or embodiment, now known or hereafter to become known, including, but not limited to, all formats of computer readable electronic magnetic, digital, laser or optical-based media;

(3) use and permit to be used my name in connection with the Pictures or Works as MH may choose;

(4) display, perform, exhibit, distribute, transmit or broadcast the Pictures or Works by any means now known or hereafter to become known.

Waiver and Release

I hereby waive all rights and release MH, its Board of Directors, officers, managers, employees and agents from any claim or cause of action, whether now known or unknown, for invasion of right to privacy, publicity or personality or any similar matter, or based upon or relating to the use and exploitation of the Pictures or Works.

I agree that there shall be no obligation to utilize the authorization granted by me hereunder. The terms of this authorization shall commence on the date hereof and be without limitation except as stated below.*

I agree to execute Memorial Hermann Healthcare System's Authorization for Disclosure of Protected Health Information as it applies to this release. I am aware of my privacy rights.

I warrant and represent that I am over the age of eighteen years and that I am free to enter into this agreement.

_____ _____
Signature Date

NOTE: If under the age of eighteen years, have a parent or legal guardian execute the following: I approve and agree to the foregoing. My _____ (insert "son," "daughter" or "ward") is _____ years of age.

_____
Signature of Parent/Guardian Signature of Witness _____

Date _____

*** I have the right to request cessation of recording or filming.**

Project: _____ MSR: _____

❑ Video ❑ Still ❑ Web

Contact Information
(Only necessary if you have not completed the HIPAA Consent form.)

(Please print) Name: _____ Address: _____

Phone number: _____ _____