Multnomah County Communications Office
501 SE Hawthorne Blvd., Suite 600
Portland, OR 97214

Publicity Release

RACE VIP Partnership Project Name _____

Date _____

I understand that Multnomah County might include my image, name, or statements for the purpose of telling stories or informing the public about county programs.

The county may use my image, name, or statements in any of the following ways: Photographs, Videos, Voice recordings, Television, Web sites / Social media

I agree that:

❒ the County may use my image, name, or statements at any time.

❒ the County may use my images, name or statements until

_____(date) ❒ the County may give my images, name or statements to another media outlet for its use.

I release and discharge Multnomah County from any lawsuits or demands for damages arising from the use of my name, image, or statements, including any claim for libel or invasion of privacy. If I am under 18, my parent or legal guardian has signed on my behalf and agrees to the terms of this document.

Print name _____

Signature _____

Print parent / guardian name _____

Parent / guardian signature _____

Telephone _____ Email _____

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Authorization to disclose health information

Name _____

Date of Birth _____

I authorize:

- ❒ Multnomah County Health Department
- ❒ Multnomah County Department of Community Justice
- ❒ Multnomah County Aging, Disability & Veterans Services
- ❒ Multnomah County Developmental Disabilities

to disclose my name, address, phone number, image & information about my health with the Multnomah County Communications Office for the purpose of telling stories or informing the public about county programs.

...

I may cancel this authorization at any time by writing to the county office listed above. If I do that, Multnomah County will not provide my information to anyone else. Once the County has disclosed my information to another party, you may ask the other party to stop using the information, but the county cannot require the other party to stop using the information.

I can refuse to sign this form, and none of my information listed above will be disclosed to the

communications office. This form is not required to receive treatment, payment for treatment, enrollment in health insurance or for eligibility of benefits.

This authorization will expire 10 years from the date below.

I may ask for a copy of this form.

Signed _____ Dated _____

If this form is signed by someone on behalf of another person (such as a child under the age of 18), please complete the fields below:

Name of Personal Representative (print) _____ Relationship _____

Signature of Personal Representative _____