Bethesda Fertility Center

MARKETING COMMUNICATIONS AUTHORIZATION FORM
(Authorization for Use of Photographs, Recordings and/or Interview Material)

Name of Participant or Patient**:** _____

Address: _____

Phone #: _____

Email: _____

I hereby voluntarily authorize Bethesda Inc. and its grantmaking initiative – Bethesda Fertility Center, bi3, TriHealth, Inc., Bethesda Hospital, Inc., The Good Samaritan Hospital of Cincinnati, Ohio (the "Assignees") and/or their subsidiaries, affiliates, agents, contractors, providers or employees to interview, record and/or take photographs of me. I understand that the term photograph may include, but not be limited to, videotape, videodisc, digital image and any other mechanical means of recording or producing visual images (hereinafter referred to as "photographs"). I also understand the interview session may involve, but not be limited to, audio tape, or other recording device, written recording or other mechanical means or medium to preserve the discussions (hereinafter referred to as "interview material").

I understand and agree that the photographs and/or interview material may also be used and/or disclosed to the public for any and all other purposes deemed appropriate by the Assignees, and/or any subsidiaries, and affiliated organizations of such entities. Such purposes may include, but not be limited to education, treatment, public relations, advertising, communication materials, promotional and marketing publications (including postings on an organization's website), social media (such as, but not limited to, Facebook, YouTube, Twitter, etc).and/or fundraising activities.

I agree to hold harmless the Assignees and their authorized parties involved in the production, duplication, publication or other use and/or disclosure of the photographs, and/or interview material for any damages or losses incurred by such use and/or disclosure of the photographs and/or interview material. I also understand that the photographs and/or interview material used and/or disclosed pursuant to this authorization may be re-disclosed by a recipient and such cannot be controlled by any of the aforementioned parties.

In addition, I waive all rights to or conditions on the use and/or disclosure of these photographs and/or interview material that I may have pursuant to this authorization and waive any claim for payment or royalties related to the production, duplication, publication or other use and/or disclosure of the photographs or interview material by the assignees, or any subsidiary or affiliate, or any other party involved in any use and/or disclosure now or in the future.

Expiration. This authorization will expire when no further production, duplication, publication or reprint or any other use of the photographs or interview material is required by the Assignees and/or their subsidiaries or affiliates.

Revocation. I understand that I may revoke this authorization at any time by notifying Bethesda Inc. by calling 513-569-6100. I understand that if I revoke this authorization, it will not affect any actions the Assignees and/or their subsidiaries and affiliates took before Bethesda Inc. was notified of my revocation. For example, Bethesda Inc. cannot rescind a publication of my photograph or interview material made before it received my revocation letter.

Bethesda Fertility Center

ADDITIONAL INFORMATION IF A SPECIFIC MEDIA INTERVIEW OR STORY IS INVOLVED:

Recipient of the Information: I authorize the following person(s) or organization(s) to receive the information:

_____

MEDIA VENUE(S)

Personal Health Information to be released by Bethesda Inc. other Assignees: Note details in the space below.

OK TO RELEASE YOUR CONTACT INFORMATION TO THE MEDIA? ☐ or ☐
OK TO ARRANGE FOR AN INTERVIEW WITH A REPORTER? ☐ or ☐
OK FOR DOCTOR(S) TO DISCUSS YOUR MEDICAL CASE WITH MEDIA? ☐ or ☐

Name: _____

(Please print name of participant or patient)

Signature: _____ Date: _____

If the participant involved is under 18 or unable to grant authorization, his/her parent or legal guardian must provide authorization;

I hereby certify that I am the parent or legal guardian of _____, named above. I do give my authorization without reservation to the foregoing.

Name of Participant's parent or legal guardian: _____

(Please print name of parent or legal guardian)

Signature: _____ Date: _____