COLUMBIA UNIVERSITY IRVING MEDICAL CENTER
PUBLISHING AND BROADCASTING RIGHTS MEDIA RELEASE

Program Description: _____

Department: _____

Staff Member Obtaining Authorization: _____
Please Print

I have been asked to participate in the production of a health media initiative (the "Program") which will be produced and distributed by any and all media (the "Producers"). The Columbia University Irving Medical Center ("CUIMC") has permitted the Producers to film one or more segments of the program at facilities maintained by CUIMC.

I agree to be photographed, interviewed, filmed, videotaped, and/or recorded by the Producers. As part of my participation in the production of one or more segments of the program, it will be necessary for the Producers and/or CUIMC to use, simulate, and/or portray my name, voice, appearance, likeness, picture, image, personality, and statements made by me (collectively, "my personal information") in connection with the production, distribution, promotion, advertising, and exploitation of the Program.

I hereby consent and grant to CUIMC and any persons or entities authorized by CUIMC (the "CUIMC Group") and the Producers the irrevocable, perpetual and worldwide right and permission to use, reuse, copy, modify, alter, create derivative works, publish, perform, display, and transmit my personal information, whether recorded on or transferred to videotape, film, slides, photographs, audio tapes and recordings, electronic files, or other media, now known or later developed, in videotapes, audio and video recordings, internet postings or other web publications of the filmed, videotaped, and/or recorded likeness of me (collectively, my "Image"), alone or with other persons in any and all media and formats now existing or subsequently developed, in their sole discretion, for purposes of the Program.

I understand that the information used and disclosed will include my personal information, such as my name and other identifiable information, including that described in the HIPAA Authorization for Media Release Form and other information about my medical condition.

I waive any right I may have to inspect or approve any uses made of my Image in connection with this Release.

I agree to hold harmless and release the CUIMC Group from any and all claims, demands, or causes of action (collectively, "Claims") that I or my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate, have or may have by reason of this Release, whether now or in the future, relating to the use of my personal information and Image in connection with the production, distribution, promotion, advertising, and exploitation of one or more segments of the Program in all media and distribution channels of any kind, including without limitation, any Claims for libel, defamation, invasion of privacy or right of publicity, infringement of copyright, or violation of any other right of mine. I further agree that any negatives, prints, or other material for printing or reproduction prepared in connection with the use of my personal information by the Producers shall be the sole property of the Producers or CUIMC.

By signing below, I acknowledge that I have completely read and fully understand the above Release and agree to be bound by the terms described herein.

I certify that I am over the age of eighteen (18) years and have legal capacity to sign this form.

By signing this form, I acknowledge that I have read and accept all of the above.

Patient Name (print):_____ Date: _____

Signature (of patient or representative*):_____

Address: _____

Email: _____ Phone No.:_____

**** Parent or other legal representative must sign if patient is under 18 years of age or legally incapable of consent***

If signed by someone other than the patient (parent, guardian, or other legal representative):

Name of Representative:_____ Relationship to patient:_____

COLUMBIA UNIVERSITY IRVING MEDICAL CENTER
HIPAA AUTHORIZATION FOR MEDIA RELEASE

By signing this Authorization, I hereby give permission for Columbia University Irving Medical Center, its affiliates, business partners, and agents (together, "CUIMC") to disclose my personal information, including information about my medical condition, health treatment, and prescription drugs (collectively, "Health Information") to any and all media (the "Producers") for the health media initiative described in my signed Publishing and Broadcasting Rights Media Release Form ("Media Release Form").

I understand that CUIMC is ____ is not ____receiving payment from the Producers for participating in the health media initiative described in this form and in the Media Release Form.

I understand that I may refuse to sign this form and that if I do not sign it, I may not be permitted to participate in any aspect of the health media initiative.

However, my refusal to sign will not affect my ability to receive treatment from my health care provider, nor will it affect my payment, enrollment, or eligibility for health benefits.

I understand that there is the potential for information disclosed pursuant to this Authorization to be subject to redisclosure, and that it may no longer be subject to federal privacy protections.

I understand that I may revoke this Authorization at any time by writing to: Privacy Officer/Office of HIPAA Compliance - Columbia University Irving Medical Center, 630 West 168th Street, Mail Box 159, New York, N.Y. 10032. My revocation will be effective upon receipt, but my revocation will not affect uses or disclosures of my Health Information previously disclosed in reliance upon this Authorization.

I understand that this Authorization will remain valid for one (1) year from the date I sign, unless I revoke it earlier.

I understand that I will receive a copy of this Authorization.

By signing this form, I acknowledge that I have read and accept all of the above.

Patient Name (print):_____ Date:_____

Signature (of patient or representative*):_____

Address: _____

Email:_____ Phone No.:_____

**** Parent or other legal representative must sign if patient is under 18 years of age or legally incapable of consent***

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