Consent to Publish, Photograph or Interview

This consent shall be completed when an individual agrees to be interviewed, photographed, or videotaped on the premises of a Marshall Health Network facility or at sponsored events for marketing, news media, social media, advertising, documentation, or educational purposes.

Name ____ **Date** _______________

The undersigned does herby consent to permit Marshall Health Network, affiliated with Cabell Huntington Hospital, St. Mary's Medical Center, Rivers Health, and Hoops Family Children's Hospital to:

- Use the undersigned's name, comments, or likeness (including photographs, images, and videotape) in connection with any publication (including, but not limited to newspapers, television, internet, and intranet websites and or radio broadcasts, books, brochures, magazines, newsletters, videotapes or motion pictures) in such a manner and at such time sand in such places as the Network or its authorized representatives, in their sole discretion, shall determine.
- Use the undersigned's name, comments, personal information, or likeness (including photographs, images, and videotape) in connection with displays, exhibits, educational materials, promotional materials or presentations about the Network, its services and/ or the experiences of its patients and families.
- Use any quotations and comments made verbally or tape recorded by the undersigned and/ or concerning the undersigned and/ or the undersigned medical care and treatment.
- Take, reproduce, or post on the Network's internet or intranet websites (to include social media websites such as Facebook, X and YouTube) photographs, images, and videotape of the undersigned in connection with the undersigned's diagnosis, care, and treatment (including surgical procedures), or the undersigned's participation in Hospital sponsored events on or off Hospital premises.
- Use such photographs, images, or videotapes for scientific and educational purposes.

The signatures below constitute an agreement by the undersigned to release the information, interview or images as mentioned.

I understand that I have the right to request that photography, filming, or recording be stopped at any time, and that I may rescind this consent within a reasonable time before the recording, photograph, image, or videotape is used.

I waive all rights that I may have to any claims for payment or royalties in connection with any exhibition, televising, publication of photographs or quotes, motion pictures or video tapes, regardless of whether such exhibiting, televising or other showing is under philanthropic, commercial, institutional, or private sponsorship and irrespective of whether a fee of admission or film rental is charged.

I release Marshall Health Network, their hospital affiliates, employees, agents, representatives, consultants, and associated parties from any liabilities in connection with the use of such material in accordance with this release.

Signature: ______________________________ **Witness:** ___________________________
(Parent or Guardian if individual is a minor)

Address: ________________________________ **Phone Number:** _______________________

E-mail: ____