I, __________________________, hereby agree to grant to Montefiore Nyack Hospital, its successors and all persons acting under its permission or authority including, but not limited to, its employees and agents permission to photograph, publish, reproduce, record and use photographs, motion pictures, videotapes or audio tapes (collectively referred to as “Images”) of me (or my child, __________________________ [INSERT NAME]), in order to memorialize the medical care, surgery, any other procedures to be performed, my presence at Montefiore Nyack Hospital, attendance at Montefiore Nyack Hospital events and/or participation in Montefiore Nyack Hospital research studies. The Images may be used for any and all purposes, including but not limited to distribution to the media, educational, promotional, publicity, advertising and fundraising purposes, as well as for possible publication by Montefiore Nyack Hospital in various traditional and social media (e.g. Facebook) and on the Internet. I acknowledge and agree that Montefiore Nyack Hospital will not pay me (or my child) in any manner for such photographing/recording and use of the Images. I grant this permission and release as a voluntary contribution and I waive any and all rights I (or my child) may have to royalties or other compensation in connection with any such publication or use. I hereby waive my right to inspect and/or approve the finished products and final usages. I hereby release and discharge Montefiore Nyack Hospital from any liability by virtue of any blurring, distortion, alteration, optical illusion or use in composite form that may occur or be produced in the creation or processing of any images created by Montefiore Nyack Hospital. The foregoing permission is granted for the entire time period during which I (or my child) receive(s) outpatient and inpatient treatment and/or participate in a research study at Montefiore Nyack Hospital and the right to use the Images shall continue until such time that the footage, photographs and other images are no longer used by Montefiore Nyack Hospital for educational, promotional, publicity, commercial and fundraising purposes. I also understand that I may contact the Montefiore Nyack Hospital Public Relations Dept. in writing to revoke future uses, but that my revocation will not affect disclosures of information that have already occurred. I understand that I am not required to sign this form authorizing the use of Images, and I may refuse to do so without any effect on my receipt of care at Montefiore Nyack Hospital.

FORM CONTINUES ON BACK >>
I hereby release Montefiore Nyack Hospital, its trustees, officers, employees, physicians, agents and assigns from any and all legal liability that may arise from any of the foregoing and I waive any and all rights I (or my child) may have to royalties or other compensation in connection with any of the foregoing.

__________________________________________  ____________________________
NAME (PRINT)                                      SIGNATURE

__________________________________________  ____________________________
ADDRESS                                         DATE

__________________________________________  ____________________________
EMAIL ADDRESS (OPTIONAL)                        PHONE

IF PARTICIPANT IS A MINOR:

__________________________________________  ____________________________
RELATIONSHIP                                   NAME (PRINT)               DATE OF BIRTH

WITNESS:

__________________________________________
NAME (PRINT)

__________________________________________  ____________________________
SIGNATURE                                      DATE