Mercy Medical Center – Des Moines
GENERAL AUTHORIZATION TO BE PHOTOGRAPHED AND/OR INTERVIEWED

Name of Participant: ______________________________

I hereby voluntarily authorize Mercy Medical Center – Des Moines ("Mercy") and/or its parent corporation, affiliates, agents, contractors, providers or employees to interview and/or take photographs and/or interviews of me. I understand that the term photograph may include, but not be limited to, videotape, digital image and any other means of recording images (hereinafter referred to as "photographs"). I also understand the interview may involve audio tape, recording devices, or other means to preserve the discussions (hereinafter referred to as "interview material").

I understand and agree that the photographs and/or interview material may be used and disclosed for any purposes deemed appropriate by Mercy. Such purposes may include, but not be limited to, education, treatment, public relations, advertising, communication materials, promotional and marketing publications, and/or fundraising activities.

I understand that I may refuse to sign this Authorization, that there is no obligation to participate and as applicable treatment, payment, enrollment in any health plan, or eligibility for benefits will not be conditioned upon my providing this Authorization for the use and/or disclosure of photographs or interview material.

I agree to hold Mercy harmless, and its parent corporation, subsidiaries, affiliates, agents, officers, contractors, providers, directors, and employees for any damages or losses incurred by such use and/or disclosure of the photographs and/or interview material.

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 and waive any claim for payment or royalties related to the use and/or disclosure of the photographs or interview material by Mercy, its parent corporation, subsidiary, affiliate, or any other party involved in any use and/or disclose now or in the future.

I further understand and agree that these photographs and/or interview material may be used beyond the initial purpose and expiration date, if any listed below, for archival and/or historical purposes by Mercy, its parent corporation, subsidiaries or affiliates.

This Authorization is binding: The statements made in this Authorization are binding, controlling, and I understand that they take precedence over prior statements made including as applicable, those contained in Mercy's Notice of Privacy Practices.

Name: ______________________________

(Please Print) Date: ______________________________

Signature: ______________________________ Date: ______________________________

Witness: ______________________________ Date: ______________________________
Minors:
If the participant involved is under 18 or unable to grant this Authorization, the guardian or legal representative must provide Authorization;

I hereby certify that I am the guardian or legal representative of______________________________, named above. I do give my Authorization without reservation to the foregoing.

Name of Participant’s guardian or legal representative: ____________________________________________

(Please print name of guardian or legal representative)

Signature: ______________________________ Date: __________________

Witness: ______________________________ Date: __________________

Expiration: (Choose one)
This Authorization expires on _______________ (Insert date if applicable)

OR
Check this box below if applicable:

☐ When no further production, duplication, publication or reprint or any other use of the photographs or interview material is required by Mercy, its parent corporation, subsidiaries or affiliates.

Revocation:
I understand that I may revoke this Authorization at any time by notifying Mercy in writing by sending a letter to: Mercy Medical Center- Des Moines 1111 Sixth Ave. Des Moines, IA 50314 Attn: Public Relations and Marketing Department. I understand that if I revoke this Authorization, it will not affect any actions that Mercy took before it received my revocation letter.

Name: ______________________________________________________

(Please print name of participant)

Address: ______________________________________________________

______________________________________________________________

(City/State/Zip)

Phone Number: ________________________________________________

Signature: ______________________________ Date: ________________

Witness: ______________________________ Date: ________________