Media Authorization Consent to Release Information (CAOS)

Name:_____ MRN/Badge#:_____ Date of Birth:_____/_____/_____

Phone:_____ E-mail Address:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Throughout this document the reference to "Carle" collectively refers to Carle Health including Carle Foundation Hospital, Carle Physician Group, Carle Hoopeston Regional Health Center, Carle Richland Memorial Hospital, Carle BroMenn Medical Center and Carle Eureka. I authorize **Carle** to **release information** about me as follows:

1. **Carle** may use and/or disclose the information described below to the general public, through media, Carle publications or in other public venues including, but not limited to, print materials, social media, radio, television, and the internet.

2. I understand that the **purpose** of the disclosure(s) is for Carle's own marketing activities and/or general public information, awareness, education, and/or fundraising.

3. **Specific Records and/or Information** to be disclosed verbally, in writing or electronically, as the case may be: photos, videos, and/or audio recordings and transmissions of me/my child and reproductions of the same, beginning on date of enrollment at Carle Auditory Oral School.

4. **Revocation, Re-disclosure, & Expiration.** I understand that I may revoke this authorization at any time by submitting a written request to the Marketing & Communications department at 611 W. Park Street, Urbana, IL 61801, unless Carle has already acted upon my authorization. I understand that my revocation only applies to uses and disclosures of my personal information by Carle. I further understand that any information already disclosed pursuant to this authorization is no longer protected by the laws and regulations applicable to Carle, and may be subject to re-disclosure. Unless specified otherwise by me, this Authorization will have no expiration date.
   (Optional expiration date/event:_____).

5. I understand that my authorization to disclose the above information is **voluntary**, and Carle will not condition the provision of treatment or payment on this authorization.

6. **I waive any right to inspect or approve** the material prior to its use. All reproductions of my medical or personal information shall remain the property of Carle and may be edited prior to use. Furthermore, I release Carle, their licenses, agents, successors and assigns from any and all claims for damages for libel, slander, invasion of privacy or any other claim based upon the use and/or disclosure of my information.

COPY OF THIS AUTHORIZATION: I have been offered a copy of this authorization for my records.

_____ _____

Signature (Parent/Guardian/Authorized Signature where applicable) *Date*

_____ _____

Authority to Sign, if not the Patient/Employee *Date*

Carle