Northwestern Medicine

AUTHORIZATION TO OBTAIN, USE AND DISCLOSE IMAGES AND OTHER MEDIA FOR PATIENTS AND NON-PATIENTS*

By signing this form, I hereby authorize Northwestern Memorial HealthCare (NMHC), its current and future affiliates and subsidiaries ("Northwestern Medicine") to create, obtain, record use and disclose photography and/or video or audio recording in print, digital or video media ("images and other media"). As applicable, I also authorize Northwestern Medicine personnel to interview me and to obtain, use and disclose related information obtained for the purposes described in this form.

The permitted uses and disclosures of this information, images and other media may include without limitation:

- Northwestern Medicine publications (online, electronic and/or print)
- Fundraising, publicity, promotion, websites or advertising
- Marketing as defined in the federal privacy regulations
- Posting on Northwestern Medicine websites (internal and external) or any Northwestern Medicine use of social media (Facebook, Twitter, Instagram, YouTube, Pinterest, etc.)
- Released to the print and broadcast media (e.g. radio, television, newspaper, magazines), third parties, third party websites, social media, and all other types of electronic communication.
- Other: _____

I further consent to my information, images and other media being stored and managed within Northwestern Medicine for future use, unless I indicate otherwise. I also understand that once information, images and other media are disclosed pursuant to this authorization, it is possible that such material will no longer be protected by federal and state privacy laws and could be re-disclosed by the person or entity receiving such material. I hereby waive the right to receive a copy, inspect or approve the images and other media and also waive any and all rights that I may have to any claims for payment or royalties in connection with the above use of the images and other media.

I acknowledge that the images and other media will remain the sole property of Northwestern Medicine. I also understand that Northwestern Medicine is not receiving any financial or other compensation from third parties for use of the images or other media. I understand I have the right to refuse to sign this Authorization and that this Authorization is valid unless I cancel or revoke it in writing. If I choose to revoke this Authorization at any time in the future, I will send my revocation to NMHC Marketing, Communications and Media Relations at 541 N. Fairbanks Ct., Suite 1850, Chicago, Illinois, 60611. My written revocation will not affect any disclosure made before the receipt of my revocation by Northwestern Medicine.

I have read, understand and agree to the conditions of this Authorization by signing below.

Patient*/Individual (Non-Patient) Signature	Patient/Individual (Non-Patient) Name (Please Print)

Legal Representative Signature*	Legal Representative Name (Please Print)	Relationship	Date

Minor(s) Name(s) (When Applicable)	Age(s)	Relationship to Patient/Child (When Applicable)
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Phone Number	Email Address	Address