



**CONSENT TO PARTICIPATE IN MEDIA, ADVERTISING, MARKETING, PROMOTIONAL AND/OR FUNDRAISING ACTIVITIES & AUTHORIZATION FOR RELEASE OF PROTECTED OR CONFIDENTIAL INFORMATION (“CONSENT AND AUTHORIZATION”)**

Patient/Participant Name:

\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

1. I authorize and give consent to Penobscot Community Health Center, Inc. (PCHC), and all entities acting on its behalf, to take and use images (photographs or videotape) or sound recordings of me, or the minor patient, or person named above for whom I am legally authorized to give consent, and to disclose protected and/or confidential patient information about me, or the minor patient, or the person named above for whom I am legally authorized to give consent, including but not limited to name and the story/narrative that I provide. I understand that the intended use of such images and protected and/or confidential information is for PCHC’s media, advertising, marketing, promotional and/or fundraising purposes and that these images may or may not be used in PCHC’s sole discretion.
2. I understand that images may be used in whole or in part, or composite or distorted in character or form, without restriction as to changes or alterations, in conjunction with my own or a fictitious name, or reproductions thereof in color or otherwise, made through any medium by PCHC or any entity acting on behalf of PCHC, and in any and all media now or hereafter known, specifically including but not limited to print media and distribution over the internet for illustration, promotion, art, editorial, advertising, trade, or any other purpose whatsoever (the “product”).
3. I consent to the digital compositing or distortion of the portraits or pictures, including without restriction any changes or alterations as to color, size, shape, perspective, context, foreground or background. I also consent to the use of any published language, narrative, captions, text or any other matter in conjunction with such photographs.
4. I waive any right to inspect or approve the product and the advertising copy or other matter that may be used or the use to which they may be applied.
5. I waive any right to or interest in the confidentiality of the patient information I disclose or images taken and disclosed to the public and understand that all negatives, prints, digital reproductions, recordings, and videotapes shall be the sole property of PCHC and shall not be returned to me or any individual on behalf of whom I am legally authorized to give consent.

6. I acknowledge that this release is being made solely for the benefit of PCHC and without any expectation of compensation or other benefit to me, or the minor patient, or person named above for whom I am legally authorized to give consent, and I and forever waive any claim to such benefits.
7. I release and forever discharge PCHC (including without limitation all corporate affiliates and officers, directors, trustees, employees, and agents) from any and all claims, liability, actions, suits, demands, costs, expenses or indebtedness arising out of, related to, or in any way connected with the use of images, products, or disclosure of the information and materials described herein.
8. I understand that once I disclose protected and/or confidential information it may no longer be protected by federal or state law or applicable regulations.
9. I understand that this authorization can be revoked at any time, **except** where PCHC has already used or has relied upon the use of the images or product in producing and/or launching any media, advertising, marketing, promotional and/or fundraising activities. Where I choose to revoke this authorization in a manner consistent with this Consent and Authorization, I will send notice of the same to:

Penobscot Community Health Center, Inc.  
 Attn: Chief Communications Officer  
 103 Maine Avenue  
 Bangor, ME 04401  
[communications@pchc.com](mailto:communications@pchc.com)

10. I understand that this Consent and Authorization is fully voluntary and I have not been induced in any way to sign it. I understand that the person named above's ability to receive health care services, eligibility for benefits, or reimbursement for services is not conditioned on the signing of this Consent and Authorization.

**I have read and understand this Consent and Authorization, and all of my questions have been answered.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Participant; OR  
 Parent or Guardian; OR  
 Individual with Legal Authority to Consent

If not signed by Patient/Participant on his or her own behalf, indicate relationship to the above-named individual: \_\_\_\_\_