

Authorization for Use/Release of Colleague Information/Photography

**TO BE FILLED OUT BY MINISTRY STAFF**

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Witness Name and Title *please print* Witness Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Colleague Name, *please print*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_\_ – \_\_\_\_\_\_\_\_\_\_\_

Birthdate or Employee ID number Phone Number

1. **Person(s) authorized to use/disclose**.I permit any authorized representative or agent of Trinity Health and its affiliates to share my identity and employee or protected health information, including related interviews, images, quotes, comments and videos internally, for educational or business purposes, or externally, for social media, public relations, public affairs or similar activities
that may include advertising, marketing. Specific projects include:

*REQUIRED: Describe expected project(s) here, for instance, "Employee Recruiting Campaign," "Service Line Awareness," testimonials, advocacy.*

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1. **Recipients**. I understand that other individuals, organizations or businesses may receive my information either directly or indirectly and that they may share it with their own audiences. I further understand that Trinity Health and its affiliates have no control over such reuse of my information. Recipients may include:
* Public audiences
* Journalists, media outlets and/or their representatives
* Other health care and/or government organizations
* Local, state and/or federal policymakers
* Researchers or educators

1. **Compensation**.I understand that I will not be compensated in any way for participating in this agreement or for the use of my image, quotes, comments or information.

4. **Term**. I authorize the storage, reuse and re-disclosure of the information described above from today's date until the end of the described project. If the project has an indefinite term this Authorization will be in effect for five (5) years. I understand that I may revoke my permission prior to the end of the project by calling (with appropriate verification of my identity), mailing, faxing or taking a
letter and proof of my identity in person to the Marketing and/or Communications department at the Ministry that initiated this authorization.

5. **Statement of Understanding**. I understand that neither Trinity Health nor any of its affiliates can require me to sign this authorization as a condition of my employment, compensation, getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan.

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Signature Date

**RHM LOGO HERE**