



MARKETING CONSENT RELEASE

Name: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone: _____

Email Address: _____

I hereby give Audubon County Memorial Hospital & Clinics the absolute and irrevocable rights to use my name, quotes, testimonials, biographical information, health information, and/or photos and images for the purpose of news media (online, print, broadcast, etc.), publications and/or promotional videos, advertisements, website, and social media, medical and/or educations training, or any other lawful purpose.

I understand that my name and/or the images may be used for display or advertisement for the website, social media, and/or literature published. I hereby waive the right to inspect or approve the images prior to any forms of usage. I understand that the images may be modified to be used as design elements.

By signing this agreement, or by signing this agreement on behalf of a minor in the state of Iowa, I am giving Audubon County Memorial Hospital & Clinics the right to use my name and own the images and use them for any purposes without further approval from me. I am releasing all rights to any images. I understand that I may refuse to sign this authorization and that my treatment, payment, enrollment, or eligibility for benefits will not be conditional on my signing or refusing to sign this authorization.

I understand that images and data could be captured or used by others without the permission of Audubon County Memorial Hospital & Clinics, and I waive any claims I may have against Audubon County Memorial Hospital & Clinics for any such unauthorized use.

I agree to hold harmless, Audubon County Memorial Hospital & Clinics from any and all actions, claims, and demands arising out of or in connection with the use of all or any part of the photographs (including computer images or reproductions of any kind), including any editorial or comment which may accompany the images in their displayed format and/or my name.

I do now and shall in the future hold Audubon County Memorial Hospital & Clinics, its successors, and assignees, as well as the physician(s) involved with my care, blameless and free from any claims in connection with the consent and use of the materials specified above.

I understand that after information is disclosed, it may no longer be protected by federal privacy regulations. I understand this authorization is voluntary, without compensation, and I may revoke it at any time by providing written notice to Administration, Audubon County Memorial Hospital & Clinics, 515 Pacific Ave., Audubon, IA 50025. The revocation will not affect actions taken before the receipt of this written notification.

This form has been explained to me, or I have read and fully understand this form, and all questions that I have asked, have been answered to my satisfaction.

Authorization:

Signature (Subject or Representative)

Date

Relationship (if representative)

Return to the Office of Administration, Audubon County Memorial Hospital