Trinity Health

Trinity Health Of New England

General Authorization for Use/Release Information/Photography

* Note: This form is for use with individuals who are neither patients, nor employees of Trinity Health. It is not a HIPAA-compliant patient authorization and is therefore not for use with patients. If the subject is also sharing protected health information or their patient experience, please ensure compliance by obtaining their authorization using the patient form.

_____
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 personal 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 or marketing. Specific projects include:

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

   _____

   _____

   _____

2. **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

3. **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 two (2) 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.

_____ _____ _____
Signature Relationship to Signer if other than signer Date

TO BE FILLED OUT BY MINISTRY STAFF

_____ _____ _____
Witness Name and Title *please print* Witness Signature Date