

AUTHORIZATION AND RELEASE TO USE LIKENESS / INFORMATION

Patient Name: \_\_\_\_\_  
(Last) (First) (Middle)

I, or my authorized legal representative, hereby give consent for Onslow Memorial Hospital ("OMH"), its employees, agents, and/or contractors to use and/or disclose my information and likeness or image including, but not limited to, photographs, videotaped images, audio recordings, digital or other images (collectively referred to as "Image(s)") as follows:

I agree to allow OMH to use/disclose (check all that apply):

\_\_\_\_\_ My Image(s) \_\_\_\_\_ Other information: (Describe):  
\_\_\_\_\_ My Name \_\_\_\_\_  
\_\_\_\_\_

For the following purpose(s):  
\_\_\_\_\_

I understand that my authorization to use/disclose my Image(s) is valid and binding for a period of **twenty (20) years** from the date of execution unless otherwise revoked before that time by the appropriate method stated herein.

**I understand that OMH and its regents, employees, agents, and/or contractors shall not be held responsible for any use of my name and/or image(s), including any use whatsoever by any outside user or third parties, and I hereby release and hold harmless OMH and its directors, officers, employees, agents and/or contractors from any and all liability for damages of whatever kind, character or nature which may at any time result from this release and authorization or from the dissemination of my information and/or image(s) in accordance with this Authorization and Release. I understand that if the above-stated purpose is for marketing or publicity, then the information described herein may be disclosed to the general public.**

I understand that OMH will own the Image(s) of me, but I have the right to see them or obtain copies of them at a reasonable cost. I do hereby knowingly and voluntarily waive any and all other rights, compensation, royalties, or payment of any kind or character in connection with the use of my information and/or image(s) as authorized above.

This Authorization and Release can be revoked at any time, but such revocation must be in writing and sent to:

OMH Privacy Officer  
317 Western Blvd.  
Jacksonville, NC 28546

Any revocation of authorization to use/disclose my Image(s) pursuant to this Authorization and Release does not affect any information used or disclosed prior to receipt of the written notice of revocation. **By signing below, I hereby indicate that I have read and understand this Authorization and Release and that it is binding on my/the patient's heirs, executors and personal representatives.** I certify that I am the patient (or the patient's legal representative authorized to sign this document on behalf of the patient). This form is **optional** and I understand that **I do not have to sign it** to receive medical care.

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient/Legal Representative (If not patient, describe relationship to patient)

