



## CONSENT TO DISCLOSURE OF PHOTOGRAPH OR OTHER PERSONAL OR HEALTH INFORMATION FOR EDUCATION AND PROMOTION PURPOSES

I, \_\_\_\_\_ (name), hereby consent to my personal information and/or my individually identifying health information relating to: \_\_\_\_\_ (description of information/relevant dates, etc.) being disclosed by Covenant Health, Covenant Care, Covenant Living, and/or Covenant Foundation (collectively, "Covenant") to: \_\_\_\_\_ (name of recipient) in accordance with section 40(1)(d) of the Freedom of Information and Protection of Privacy Act ("FOIP") and/or section 34 of the Health Information Act ("HIA"), in the form of (check all that apply):

- |  |                                    |
|--|------------------------------------|
| <input type="radio"/> Still/digital photographs                | <input type="radio"/> Writing      |
| <input type="radio"/> Sound recordings                         | <input type="radio"/> Other: _____ |
| <input type="radio"/> Video recordings (with or without sound) |                                    |

For the following purpose(s) (check all that apply):

- |  |   |
|--|---|
| <input type="radio"/> Media release/interviews | <input type="radio"/> Presentations   |
| <input type="radio"/> Publications             | <input type="radio"/> Hospital displays   |
| <input type="radio"/> Education                | <input type="radio"/> Covenant websites/intranet ( <i>accessible nationally and internationally</i> ) |
| <input type="radio"/> Promotions/Advertising   | <input type="radio"/> Other: _____  |
| <input type="radio"/> Social media             |   |

I confirm that Covenant may use my name, address and telephone number for the purpose of contacting me to discuss any changes in circumstances which may be relevant to the consent. My address and telephone number are as follows:

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

Phone Number: \_\_\_\_\_

I acknowledge that I have been made aware of the reasons that my personal information (including a photographic image or images of myself) and/or individually identifying health information is needed and the risks and benefits of consenting, or refusing to consent, to the use and /or disclosure of the same. I understand and confirm that I may revoke this consent at any time.

I release and discharge Covenant, and those for whom each is responsible at law, from all responsibility and liability for the content of the above mentioned still/digital photographs, video recordings and/or sound recordings and the specific use to which they may be applied. I declare that this release and discharge shall be binding upon my heirs, executors, administrators and assigns.

**I understand that I have the right to refuse to grant this consent.**

This consent is effective this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Signature of Staff, Patient, or Authorized Representative

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Staff, Patient, or Authorized Representative

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Source of Representative's Authority (if applicable)