

Participant Media Consent and Release Form

I understand that:

1. My participation is strictly voluntary. If I do not sign this form, my health care and the payment for my health care will not be affected.
2. I will receive no compensation for my participation.
3. This consent form will expire in 100 years and the materials may be retained indefinitely.
4. I have a right to withdraw my consent at any time by contacting Public Relations (below), until a reasonable time before materials are used.
5. By signing this form, the personal health care information I relay to an outside source is no longer protected by state and federal privacy laws and may be re-disclosed by that source.

I understand that, in the instance of outside sources (such as the news media), Stoughton Health is acting only as the intermediary, making it possible for the aforementioned source(s) to contact me. I agree to hold Stoughton Health and its members, directors, officers and employees harmless from any and all liability arising out of the use and/or release of information, interview, photograph/videotape/film, and subsequent publication or broadcast.

1. CONSENT

Yes – I permit Stoughton Health to use my information/likeness for internal and external use. I understand that this includes, but is not limited to, pictures, videos, recorded interviews, etc. being shared through: Social media, print materials, advertisements, websites, TV, radio, billboards, signage, YouTube, e-mail, etc.

No – I do not consent to my likeness being shared by Stoughton Health.

2. AUTHORIZATION

Signature of Participant/ Patient/ or Guardian:	If Guardian Signed, write relationship to Participant/Patient:
Print Name of Participant/ Patient:	Participant/ Patient/ or Guardian Email:
Street Address:	Participant/ Patient/ or Guardian Phone Number:
City/State/Zip:	
Date:	

Stoughton Health Public Relations Department:
 900 Ridge Street, Stoughton WI 53589 (608)873-2248