Carolinas HealthCare System

Patient Name: ______________________________________

Date of Birth: ______________________________________

Street Address: ______________________________________

Last 4 numbers of SSN: ______________________________

City, State, Zip: ______________________________________

Telephone: (   ) ________________________________

Patient Account #: ____________________________________

I grant The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System and Carolinas HealthCare Foundation a perpetual, world-wide, royalty free license and permission to record, use, disclose, portray, reproduce, broadcast, stream, post, print, and publish my (or the person on whose behalf I am serving as a personal representative, who will be included in the terms "my", "me", "mine", or "I") likeness, picture, video, information (including that released pursuant to an Authorization), story, quotes, and interview, whether in digital, electronic, paper, print, video, oral, or televised form, ("Information") for its current or future internal and external marketing, fundraising (including by The Carolinas HealthCare Foundation), public relations, and educational purposes on behalf of The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System (including on behalf of its hospitals, practices and programs) and Carolinas HealthCare Foundation. I understand that such Information will be the exclusive property of The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System and Carolinas HealthCare Foundation, free and clear of any claim on my part and may be used in future video or print projects, in whole or in part.

I understand that I will not be compensated for the permissions, licenses, or use of the Information. I also understand that The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System and Carolinas HealthCare Foundation are only responsible for their own actions, and do not control third parties, including other media outlets. I understand that I can request that production of the recording be stopped at any time during production and I can rescind this consent before the Information is used.

On behalf of myself, my child, our heirs and representatives, I agree to release The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System and Carolinas HealthCare Foundation, their commissioners, directors, officers, and employees, from and against any liability related to their use of the Information.

Signature: ____ Date: _________________

Print Name: ____

If authorized representative signing, print patient's name: ______________________________

(If the patient lacks legal capacity or is unable to sign, an authorized representative may sign this Permission.)

☐ Healthcare agent ☐ Guardian ☐Attorney in Fact/Executor ☐ Spouse ☐ Parent /Adult Child ☐ Adult Sibling
☐ Affidavit of Next of Kin ☐ Other __________

Permission to Record & Use Likeness

December 2014