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RELEASE OF INFORMATION

I, the undersigned, request and authorize the members of Guthrie Health ("Guthrie") to allow their medical staff and/or any employees involved in my care and treatment to release information regarding that care and treatment, for the purpose of describing and/or promoting programs and/or services of Guthrie. Such descriptions and/or promotions may appear in Guthrie publications or in the media.

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RELEASE OF LIABILITY AND CONSENT TO BE PHOTOGRAPHED, FILMED, VIDEOTAPED AND/OR INTERVIEWED BY MEDIA

I, the undersigned, request and authorize the Guthrie staff to allow any media to photograph, film, videotape and/or interview me while a patient or visitor of any of the member institutions of Guthrie. I hereby release and agree to indemnify and hold harmless Guthrie, its affiliates and their trustees, officers, employees, agents, patients and medical staff from any injury and/or damages sustained as a result of such photographing, filming, videotaping and/or interviewing, including, but not limited to, claims for personal injury, property damage, invasion of privacy and/or breach of confidentiality. I agree to cause the photographing, filming, videotaping and/or interviewing to be stopped immediately upon the request of any physician or hospital/clinic employee, if in the sole judgement of said person, such is in the best interest of the care of any patient.

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PERMISSION FOR PHOTOGRAPH

I hereby authorize Guthrie, its subsidiaries, and staff members to take photographs or video of myself in whole or in part as it or the members of its staff may wish, and to use and publish the same in places and publications, and to persons as Guthrie or its staff may in it or their sole discretion consider to be of benefit to Guthrie, the medical profession or the public at large. I hereby waive any right that I may have to inspect and/or approve the finished product that may be used hereafter, or to approve the specific use to which it may be applied.

THIS IS A LEGAL CONSENT/RELEASE OF LIABILITY FORM.
PLEASE READ IT CAREFULLY.
BE SURE YOUR QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING.

NAME _____

DOB/B# _____

SIGNATURE _____

STATUS _____
(patient, visitor, family member, etc.)

WITNESS TO SIGNING _____

DATE _____

TIME (AM OR PM) _____