SuburbanHealth Organization | CME

Return Completed Form to:
Fax: 317-692-5233
Attention: Terri N.
Email: terrin@suburbanhealth.com

AUTHORIZATION FOR PHOTO/VIDEO/AUDIO AND EDUCATIONAL PRESENTATION/MATERIALS RELEASE

Name: _____

Address: _____
Street City State Zip

Telephone: _____ **Birthdate:** _____

I hereby authorize **Suburban Health Organization**, its employees and agents ("**SHO**") to photograph, record (audio/video), copyright, use and publish my likeness, photographic, audio, or video image, biographical information, and educational presentation/materials in any and all formats or portions now existing or hereafter concerned.

I understand that the likeness, photographic, audio, or video image, biographical information, and educational presentation/materials may be produced and released in any form, in whole or in part, with such alterations and changes as **SHO** desires, and that the images/educational presentations/materials may be done separately or with my name included in the release.

I understand that the purpose of the use or release of the photographic, audio, or video images, and educational presentation/materials will be for: (i) use for training, marketing or promotion of SHO or any entity under the control of or affiliated with SHO; or (ii) in conjunction with any programs to promote health.

The use or release of the images, audio, video, biographical information, and/or educational presentations/materials will be made either to the public or within **SHO**, or both, including, without limitation, commercial or noncommercial publications and exhibits.

I agree that all pictures, reproductions, plates, negatives and tapes (audio and video) of any kind relating to the images, recordings, biographical information, and educational presentations/materials are and shall remain the property of **SHO** and/or any company to whom permission has been granted, as listed above.

I understand that this Authorization for Photo/Video/Audio and Educational Presentation/Materials Release can be revoked by me at any time by submitting a written request to: Terri Neaderhiser, CME Program Administrator, 2647 Waterfront Parkway East Drive, Suite 300, Indianapolis, IN 46214.

I understand that revocation will not apply in those instances in which **SHO** has acted upon this Authorization prior to the revocation being received by **SHO**.

I understand that the images released pursuant to this Authorization may be subject to redisclosure and no longer protected by the laws applying to medical information disclosures.

I understand that **SHO** cannot require me to sign this Authorization as a condition for providing me treatment or obtaining payment for treatment, unless the treatment is related to research.

This Authorization will expire within three years from the date signed or by **December 31, 2022**, whichever is later.

Signature:	**Date Signed:**
Signature of Authorized Representative:	**Relationship:**

A copy of this Authorization must be presented to the person signing the Authorization.