Multi Media/Photo Release Form

PHOTOGRAPHY/VIDEOGRAPHY RELEASE AUTHORIZATION:

☐ I hereby grant permission to be interviewed, photographed, filmed, videotaped or audio recorded, in whole or in part **by Pullman Regional Hospital.** I also authorize and consent to the use and reproduction of said interview, photographs, films or videotapes to be used by Pullman Regional Hospital, at its discretion, for publication in newspapers, television, electronic media, social media, video or motion pictures.

☐ I hereby grant permission to be interviewed, photographed, filmed or videotaped with audio, in whole or in part, **by media sources (newspaper, tabloid, broadcasters).** I also authorize and consent to the use and reproduction of said interview, photographs, films or videotaped to used by the media, at its discretion, for publication in newspapers, television, electronic media, video or motion pictures.

I wish to provide:

☐ NO RESTRICTIONS on my image usage

☐ OTHER RESTRICTIONS (INDICATE EXACT INFORMATION INTENDED FOR RELEASE):

____

☐ Refused Photography/Videography release

EFFECTIVE DATES OF AUTHORIZATION:

____

DATE

SIGNATURE:

___________________________________ ______________________________

NAME (PATIENT OR LEGAL GUARDIAN) SIGNATURE

___________________________________ _______________

RELATIONSHIP (IF SIGNING FOR MINOR) DATE

____

ADDRESS

Pullman Regional Hospital
835 SE Bishop Blvd
Pullman, WA 99163

EXACT DOCUMENTATION OF DISCLOSURE INCIDENCE:

____________________ ____________________ _________________________

Interview/Photo Date: Name: Notes:

Original of this form will be maintained by the Community Relations Department at Pullman Regional Hospital.