CITY OF BLOOMINGTON
CONSENT TO PHOTOGRAPH/VIDEOTAPE/FILM/INTERVIEW AND/OR
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

The City of Bloomington's Public Health Division is always pleased when clients are willing to communicate their stories, experiences, and other information about services they receive from the City. Sharing your story can help others who are interested in knowing more about the services provided by the Public Health Division and can help the City promote its efforts to serve the community.

The City of Bloomington Public Health Division respects the privacy of our clients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities. The City of Bloomington seeks your permission to use your medical information and your consent to allow us to take and use audio/video/photographic material of you in internal and external communications, and distribute such materials online, in print, and in news media (such as TV, radio, newspapers, and magazines).

To ensure that the City of Bloomington is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to fill out and sign this form.

☐ I give my permission to the City of Bloomington to use my or my child's name and share details of my or his/her treatment, medical condition and experience as a client in communications produced by or on behalf of the City of Bloomington, and consent to take and make use of my and/or my child's audio/ video/photographic images in publications produced by or on behalf of the City of Bloomington (the "Production") which may include private data about me and/or my child. This permission extends both to electronic versions on the City's websites and other internet/electronic applications as well as to printed, filmed, and taped versions.

☐ I agree to appear, and to allow my child to appear, in the Production voluntarily, without a fee, salary, payment, remuneration or other compensation for the Production now or in the future. I agree that the City of Bloomington has exclusive and entire rights to showings, exhibitions, telecasts, broadcasts, rebroadcasts, and reproductions of the Production by any means, including the sharing of this information with third parties. Said rights include sound and silent, color and black and white. The City of Bloomington intends to use the Production to promote the programs and services of the City and intends to share it with the public.

☐ I agree to hold the City of Bloomington free and harmless from any and all liability arising out of the use and/or release of information related to the Production, including; interview; photograph/videotape/film; and subsequent publication, broadcast, and re-disclosure by third parties. I am 18 years old or older.

☐ I understand that:

- Some of this information is private under state and federal law, and I do not have to share it.
- I may refuse to sign this authorization form.
- My services will not be affected if I refuse to sign this authorization form.
- I may cancel this authorization at any time in writing, by sending a letter to: Communications, Bloomington Public Health Division, 1900 W. Old Shakopee Rd., Bloomington, MN 55431, but if I do, it will not have any effect on any actions taken by the City before it received my letter. The City will not be able to recall information that was already released.
- When the health information described in this authorization is disclosed (such as to a newspaper, website, radio or television broadcast) the information could be re-disclosed by a third party and may no longer be protected by federal privacy laws.
- I understand that I may see/obtain a copy of the information described on this form, if I ask for it.
- I get a copy of this form after I sign it.

This authorization will expire one year from signature unless a different date is provided: (check and complete only one box)

☐ Date: _____ ☐ When the City no longer has need for the image/video

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Client/Minor's Parent/Guardian:	**Date:**
Print Name and Address of Client and Parent/Guardian (if a minor) :	**Relationship to Minor (if applicable):**