

Photo Release Form

I, _____ (print name)

Residing at: _____

Street Address

City

State

Zip Code

hereby authorize Burke Neurological Institute (hereinafter "Burke") and its parent, successors, affiliates Burke Rehabilitation Hospital, Weill Cornell Medicine, partner Blythedale Children's Hospital and such other persons as it may engage ("Licensees"), to interview me, take and use still and/or motion pictures, voice and videotape recordings of me, my children, or my legal ward while a patient or visitor of Burke.

I authorize the use of these pictures and/or recordings, together with the right to retouch or edit the same, in any manner and in any media for the purpose of advertising Burke's services or any other purpose which Burke may deem appropriate.

I understand that any pictures/videos taken of me by Burke or Licensees are owned by them and may be included in publications posted on Burke Neurological Institute and affiliates website, marketing materials and social media networking sites.

I further agree that Burke and Licensee will have the right to attribute to me any statement made by me and said statement may be paraphrased, amplified and/or shortened.

I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected.

I am over 18 years of age and have the legal right and authority to sign for myself and any minors named herein. I hereby release Burke and Licensees from any claim or liability whatsoever in connection with the photos/filming.

Date: _____

Signature: _____

Subject/Project: _____

Employee: _____

***Please return form to Office of Institutional Advancement**

(Revised 6/2018)