LEE HEALTH

Personal Release: Agreement and Authorization of Image and Sound Recordings for Use in Media

This Personal Release (the "Agreement") is made this _____ day of _____, _____, between Lee Memorial Health System and

Name _____ Address _____

City/State/Zip _____

Phone _____ Email _____

BACKGROUND:
The person consents to being a subject of Lee Memorial Health System in media, as well as consents to Lee Memorial Health System capturing his or her images and sound recordings for use in media. The person also consents to Lee Memorial Health System writing a summary of his or her story of care within the Lee Memorial Health System for use in the media.

WHEREBY:
LEE MEMORIAL HEALTH SYSTEM IS RELEASED OF LIABILITY: I hereby grant to Lee Memorial Health System and assigns permission to license all images and sound recordings and the use of images and sound recordings and any written account of my personal story of care within the Lee Memorial Health System in any media for any purpose which may include, among others, advertising, promotion, and marketing for any product or service. I hereby agree that any images, sound recordings and the written account of my personal health story may be combined with other images, text and graphics, cropped, altered and modified I hereby waive all rights to inspect or approve all versions of the image that may be used for publication and any written copy that may be used in connection with the images. I further hereby release and hold harmless Lee Memorial Health System or any of its affiliates, employees, officers, Board of Directors, volunteers, or agents from any and all liability including any claims for libel or invasion of privacy, directly or indirectly connected with, arising out of, or resulting from, the taking and authorized use of these photographs, audiotapes, videotapes, interviews and written accounts of my personal health story.

LEE MEMORIAL HEALTH SYSTEM RETAINS ALL RIGHTS: I hereby waive all rights that I may have to any claims for payment or royalties in connection with the use of images, sound recordings and my written personal health story, and agree that Lee Memorial Health System has all rights to images, sound recordings and my written personal health story, for perpetuity unless explicitly noted in this Agreement. I further acknowledge and agree that the Lee Memorial Health System and its agents are not liable for any consideration or accounting, and further claims for any reason.

DURATION OF AGREEMENT: I hereby acknowledge and agree that this Agreement is binding on all heirs and assigns.
I further acknowledge and agree that this Agreement is irrevocable, worldwide and perpetual, and will be governed by the laws of The State of Florida, excluding the law of conflicts. Lee Memorial Health System will not refuse to treat/employ me based on whether I agree to allow my health information to be used or disclosed.
This Agreement contains the entire agreement between the parties to this release and the terms of this Agreement are contractual and not a mere recital. This Agreement will be construed in accordance with and governed by the laws of The State of Florida.

_____
NAME (PRINT)

_____ _____
SIGNATURE DATE

_____ _____
WITNESS DATE

IF THE PERSON IS UNDER THE LEGAL AGE OF MAJORITY:
I am the parent or legal guardian of the minor above named as the subject, and I have legal authority to execute this Agreement on the minor's behalf. I have read and fully understand the contents of this Agreement, and consent to the said use of images and sound recordings based on the contents of this Agreement.

_____ _____
PARENT OR GUARDIAN'S NAME (PRINT) DATE

_____ _____
PARENT OR GUARDIAN'S SIGNATURE DATE