integral care

MEDIA/PUBLICATION CONSENT

I authorize Integral Care to photograph, film and/or voice record me. This may be through photography, film, audio/video recording and/or any other available means. I give Integral Care permission to use, display, publish and distribute

1) my photograph, video and/or voice,

2) any other information about me that I have agreed to below, and

3) all or any portion of my spoken, written or other communication

with and to Integral Care employees and contractors, and the general public. This may be for marketing, advertising, public relations, fundraising, promotions, education and/or training purposes. This may be for Integral Care's behalf or on behalf of Integral Care Foundation.

For example, and not as any kind of limitation, this might include use, display, publication and distribution to the media or in printed materials (including Integral Care's and/or Integral Care Foundation's website(s) and social media channel(s)). The materials that are included within my consent in this Media/Publication Consent may be called "Materials", and this Media/Publication Consent may be called "Consent".

Check one of the following:

I am an Integral Care client ____ or the legally authorized representative of an Integral Care client ____

Staff _____ Volunteer _____ Other _____ (If other, please describe) _____

<u>THE FOLLOWING QUESTIONS ARE APPLICABLE TO INTEGRAL CARE CLIENTS ONLY:</u>

Please specify the types of information about you that you authorize for use, display, publication and distribution:

Name ____Yes _____No

Video/audio recordings ____Yes _____No

Photographs ____Yes _____No

Written communications ____Yes _____No

The following information about your medical, mental health, substance use disorder and/or intellectual/developmental disabilities condition or treatment:

Any diagnosis Yes ____ No_____

Anything I say ____Yes ____No

Anything that is visible in my home or environment Yes ___ No_____

I agree that all dates of my treatment are covered by this Consent.

The following information will not be released unless you specifically authorize it by initialing the relevant line(s) below:

____ I specifically authorize the use, display, publication and distribution of information pertaining to substance use disorder diagnosis, treatment or referral to treatment (42 C.F.R. Sections 2.34 and 2.35).

____ I specifically authorize the use, display, publication and distribution of HIV/AIDS test results (Texas Health and Safety Code Section 81.046(c)(2).

Any information that I authorize to be used, displayed, published and/or distributed pursuant to this Consent could be shared by anyone receiving it. For example, someone who looks at Integral Care's website might forward it to someone else. This disclosure may no longer be protected by state or federal confidentiality laws.

I may refuse to sign this Media/Publication Consent. My refusal will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits.

THE FOLLOWING IS APPLICABLE TO INTEGRAL CARE CLIENTS AND NON-CLIENTS:

In addition to those Materials described above, please specify the following additional types of information about you that you authorize for use and disclosure:

Name ____Yes _____No

Other (please describe in detail)_____

_____

I understand that Integral Care may use third parties, such as a hired photographer, to capture the images or recordings described in this Consent. I understand that my information will be used, displayed, published and/or distributed by these third parties as instructed by Integral Care.

I understand that all Materials will become the sole property of Integral Care free of any payment, royalty, or other compensation of any kind to me or any third party. I understand that by signing this Consent, I release to Integral Care any rights, title and/or interest of any kind that I may have in these Materials, unless and only to the extent that a legal exception may apply.

I waive any right to inspect or approve the finished product, including written words, which contain any Materials. I agree that the Materials may be edited in the sole discretion of Integral Care, and that Integral Care is under no obligation to use the Materials.

By signing I waive any right to compensation for such use, display, publication and/or distribution of the Materials by reason of this Media/Publication Consent. By signing, I and my successors or assigns release, discharge and hold Integral Care and its trustees, employees, agents and others working for Integral Care harmless from any and all claims, liability, demands, actions, and damages whatsoever which arise or could arise out of or are attributable to, in whole or in part, this Consent or any activities authorized by it.

I may request at any time that filming or recording stop. I may revoke this Consent up to the time Integral Care makes use of it, and I agree that this usage begins as soon as the work product containing the Materials is completed. If I want to cancel this Consent, I must send a written request to Integral Care at Communications@IntegralCare.org or Integral Care Communications Department, 1430 Collier Street, Austin, TX 78704. In the event that Integral Care makes use of this Consent to create marketing and/or other promotional materials featuring the Materials, I understand and agree that Integral Care has the right to use the Materials until all of the marketing and/or promotional materials in existence at the time of my cancellation of this Consent are distributed, dispersed or expire. Any cancellation of this Consent will become effective only after all marketing and/or promotional materials are distributed, dispersed or expire.

This Consent expires 15 years after the date I sign it. Upon expiration or my effective cancellation of this Consent, Integral Care will not permit further release of the Materials. However Integral Care will not be able to call back any of the Materials that are already released.

I have a right to receive a copy of this signed Consent.

I understand that a photocopy, facsimile or electronic copy of this Consent is as valid and effective as the original.

I understand that Integral Care will not receive compensation for any use, display, publication or distribution that it makes under this Consent unless an applicable legal exception applies.

CLIENT/AUTHORIZED REPRESENTATIVE SIGNATURE:

Signature: _____ Date: _____
(client or client's legally authorized representative)

Print name: _____ Date of Birth: _____
(client or client's legally authorized representative)

Signer's Contact Information:

Name_____ Email_____

Address_____ Telephone_____

_____

Complete the following if signed by a client's legally authorized representative:

Client Name_____ Signer's Relationship to Client_____

_____

NON-CLIENT SIGNATURE:

Signature: _____ Date: _____

Print name: _____