KAISER PERMANENTE®

Kaiser Permanente ("KP") Consent Form
(Includes HIPAA Authorization) – (All Markets)
Use of Photo/Image, Name, Statements, Video Recording

Use this form with KP members/patients when identifying them as a patient, health plan enrollee, or disclosing information about their health or health plan enrollment

Name of Event/Project: _____ Date of Event/Project *(if appliable)*: _____

Consent: I, _____, in exchange for valuable consideration* received, hereby grant Kaiser Permanente**, its employees, agents, and assigns, the right and permission to use, reproduce, and publish the content and creative works described in the Scope provision below, in whole or in part, for any lawful purpose, including but not limited to publicity, advertising, health education, and web content in all media ("Consent").

Scope: This consent allows Kaiser Permanente to use photographs of me, my image, my name, any stories, statements, quotes I have provided, and/or audio/video recordings of me (collectively "Content"), for any purpose including but not limited to advertising, publicity, or editorial content in print or digital format. The consent also extends to the use of my photographs, artworks, stories, songs, images, audio/video recordings, or my other original creative works ("Creative Works") in all media, including electronic, digital, Internet, print media, social medial platforms, and websites.

Warranty and License: I warrant that I own all rights in the Creative Works and have the legal right to grant Kaiser Permanente permission to use them. I further warrant that I have the written consent of every identifiable individual person in my Creative Works to use their likeness. As to the Creative Works, I grant to Kaiser Permanente a world-wide, non-exclusive, royalty-free, irrevocable, sublicensable and transferable license to use, distribute, modify, reproduce, publicly perform and publicly display the Creative Works and any related materials for any and all purposes and in all media.

I represent that all Content accurately reflects my experience with Kaiser Permanente's products and/or services and reflect my truthful and honest opinions. If and to the extent my views change, I will promptly notify Kaiser Permanente. I understand that Kaiser Permanente is relying on the accuracy and truthfulness of my Content.

Release: I understand that Kaiser Permanente may alter, edit, amplify, shorten or modify the photographs of me, my image, stories, statements, quotes, audio/video recordings, and Creative Works to meet the requirements of copy, layout and/or script, as long as the general sense is not changed. I hereby release and discharge Kaiser Permanente, its employees, agents, and assigns from any and all claims, demands, or causes of action that I may have against them in connection with the use of photographs of me, my image, stories, statements, quotes, audio/video recordings, and Creative Works. I represent and warrant that I am of legal age and have the right to enter into this agreement. If I am not of legal age, my parent or legal guardian has read and agreed to this consent on my behalf.

By signing below, I acknowledge that I have read and understood this Consent form and agree to its terms and conditions.

Signature: _____ **Date**: _____
Email: _____ **Phone number**: _____
If not signed by member/patient, specify your relationship and print your name below:

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* Consideration means anything you received in exchange for your participation in the Event/Project, whether it is a gift card or just the fun of being a part of the event or promotional activities.

** The term "Kaiser Permanente" refers to the following: Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals and their subsidiaries, each of the Permanente Medical Groups, Permanente Dental Associates, and The Permanente Federation LLC and their respective health care providers and workforce members.

KAISER PERMANENTE®

Authorization for Use and/or Disclosure of Member/Patient Protected Health Information ("Authorization")

Member/Patient Name: _____

As used in this Authorization: The term "Kaiser Permanente" refers to the following: Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals and their subsidiaries, each of the Permanente Medical Groups, Permanente Dental Associates, and The Permanente Federation LLC and their respective health care providers and workforce members.

Purpose: I hereby authorize Kaiser Permanente to use and to disclose my health information to persons involved in the preparation and production of the Images, audio/video recordings and/or statements. I further authorize Kaiser Permanente to disclose to members of the public all or any part of my name, Images, audio/video recordings and/or statements of/by me, and the health information they contain, for quality improvement, educational, scientific, treatment, research, public relations, marketing, news media, and/or charitable purposes. This Authorization also covers the use and disclosure of health information about me that may be disclosed by family, friends, or others who are interviewed or appear in the Images or audio/video recordings related to my care. The terms photographs, image, name, statements, quotes, and/or audio/video recordings have the same meaning as in the Kaiser Permanente Consent Form Use of Photo/Image, Name, Statements, Video Recording ("Consent") signed by or on behalf of the above-named member/patient.

Duration and Expiration: I understand that this Consent includes HIPAA Authorization is effective immediately and how long it lasts depends on where I live:

- California, Georgia, Hawai'i, District of Columbia, and Virginia: from the time I sign below until 12/31/2039.
- Colorado, Washington State, and Oregon: for 24 months from the date I sign below.
- Maryland: for one year from the date I sign below.

Upon expiration or revocation of this Authorization, Kaiser Permanente will not further use or disclose my name, the Images, audio/video recordings and/or statements of/by me or the medical information they contain, except as authorized by law without an authorization, but will not be able to recall any such information or material that has already been disclosed. A copy of this Authorization is as valid as the original.

My Rights:

1. I have the right to revoke this Authorization at any time prior to the use or public disclosure of my name, the Images, audio/video recordings and/or statements of/by me, or any part thereof, but I must do so in writing and submit it to the following email address:
   My revocation will take effect on receipt, except to the extent that Kaiser Permanente has acted in reliance on this Authorization.
2. I have the right to a copy of this Authorization.
3. I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment, my eligibility for benefits, payment, or my Kaiser Permanente health plan enrollment.
4. My name, the Images, audio/video recordings and/or statements of/by me, or any part thereof, disclosed pursuant to this Authorization may be re-disclosed by the recipient. Such re-disclosures may no longer be protected by federal confidentiality law (HIPAA) or state law.

Signature: _____ ***Date:*** _____ ***Time:*** _____

State of Residence: ☐ CA, GA, HI, DC, VA ☐ CO, WA, OR ☐ MD

If not signed by member/patient, specify your relationship, and print your name below:

KP Administrator's Name, Dept., Email: _____

Job/Project Name: _____ Project #/Asset # _____

(November 2023)