CURED
campaign urging research for eosinophilic disease

Authorization for Use of Photo and Videography

EVENT: ______________________________

This form gives permission for Campaign Urging Research for Eosinophilic Disease (CURED) to use and/or disclose (release) the photos and/or video of the individual below as follows:

Name: ____________________ (Last) ____________________ (First) ____________________ (Middle)   Date of Birth: ____________________

Address: ____________________ (Address) ____________________ (City) ____________________ (State/Zip)

Primary contact e-mail: ______________________________   Phone: (   ) ____________________

Information To Use/Disclose

CURED may use/disclose the following health information about the individual: *(Select all that apply)*

- ☐ Photographs
- ☐ Video recordings
- ☐ Audio recordings
- ☐ Name and age
- ☐ Parent/guardian names
- ☐ City of residence
- ☐ Diagnosis, treatment, prognosis
- ☐ All of the above
- ☐ Other: ______________________________

Purpose of Use/Disclosure

CURED may use/disclose this photo/video for the purposes described below: *(Select all that apply)*

- ☐ CURED communications, such as for marketing, advertising, public relations, fundraising, or other related purposes. This may include publications (print or electronic), presentations (at public or private events, on television), or internet sites (e.g., CURED websites, partner websites, or social media sites).
- ☐ The media, including print or television journalists.
- ☐ Professional audiences, such as publications (print or electronic), presentations or related internet sites.
- ☐ All of the above
- ☐ Other: ______________________________

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By signing below, I authorize CURED to use and/or disclose the photo and/or video specified in this authorization and confirm to the best of my knowledge that I am legally authorized to represent the interests of this individual.

- CURED will not condition payment on this signed condition.
- The information and media used and/or disclosed as a result of this authorization may be subject to re-disclosure by the person or entity receiving
- Any photos, images, or other representations specified above become the property of CURED or its representatives.
- This authorization is given without promise of compensation. The parent/legal guardian and the individual release to CURED any right, title and/or interest of any kind they may have in the information or images produced.

such information. At that point, it is no longer protected by the federal privacy regulations. CURED is not responsible for the use of information, in whole or in part, by third parties.

I understand that I may withdraw this authorization at any time. Notification of withdrawal must be done in writing and sent to CURED PO BOX 32 Lincolnshire, IL 60069. This authorization will not be withdrawn or expire for situations where CURED has already taken action as described in this authorization. This authorization will only expire if revoked by me in writing as stated above.

Signature: ______________________________   Date: ____________________

Printed name: ______________________________

This form must be signed and dated to be valid. If the individual is an emancipated minor or 18 years of age or older, s/he is required to sign the authorization.

A copy of this authorization must be provided to the individual completing this form.

__1st Copy - Event Organizer   2nd Copy - CURED