Media Release & Authorization

Child/Adult Client Participant Name: _____ Date of Birth: _____

As a parent or guardian of a child under the age of 18 or a caregiver or an authorized representative of an adult participating in Easterseals Florida's programs, services and/or events, I hereby authorize Easterseals Florida, including its employees, agents, and representatives, to create, use, and share any narratives, depictions, photographs, film, audio-visual content, sound recordings, or testimonials involving the child/client named above. These materials may be used for purposes such as illustration, public awareness, broadcast, testimonial, or other communications related to the mission and work of Easterseals.

I understand that:

- These materials may be shared with the general public through Easterseals' network of websites, social media platforms, printed materials, media outlets, and special events.
- Materials may include the child/client's photo, video, first name, disability, personal story, and comments made by the client or parent/guardian/caregiver.
- Easterseals may copyright these materials and that I assign to Easterseals my child/client's rights to these materials.
- Any use of the child/client's **protected health information (PHI)**, as defined by federal law (45 C.F.R. § 164.501), is authorized for the purposes outlined above.

To protect the child/client's privacy:

- Only the **first name** and the **geographic location** of the Easterseals organization providing services will be used.
- Full names or exact addresses will not be publicly disclosed.

I understand that:

- This authorization is **voluntary**. Easterseals will not condition services, or funding on the completion of this form.
- I will not receive any form of compensation, now or in the future, for the use of these materials.
- I may revoke this authorization at any time, by submitting a written request to the President/CEO of Easterseals Florida. I understand that any information disclosed prior to the effective date of revocation may no longer be protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- This release will remain in effect for **ten (10) years** from the date of my signature below.
- I may request a copy of this signed release for my records.

Additionally: Easterseals Florida staff may share media such as photos or videos internally (e.g., via text message) for internal approval before public use. This may involve the use or disclosure of protected health information. Such internal sharing will occur only with prior authorization from the parent, guardian, caregiver, authorized representative, or client, and will include only the information necessary for the intended review. By signing this form, you are providing this authorization.

If there is something listed above that you **DO NOT** want disclosed, please write it in the box below:

I understand that by signing below, I authorize the use of my child/client's protected health information as described in this form.

Parent/Guardian/Caregiver/Client Name (Print): _____

Parent/Guardian/Caregiver/Client (Signature): _____ Date: _____

For Office Use Only:

Easterseals Florida staff confirming receipt of this form and identity of the Parent/Guardian/Caregiver/Client signing above:

Easterseals Staff Name (Print): _____(Sign): _____ (Date):_____