Covenant Health | Covenant Care

CONSENT TO DISCLOSURE OF PHOTOGRAPH OR OTHER PERSONAL OR HEALTH INFORMATION FOR EDUCATION AND PROMOTION PURPOSES

I, _____(name) hereby consent to my personal information and/or my individually identifying health information relating to: 2024 Mission Awards (description of information/relevant dates, etc.) being disclosed by Covenant Health and/or Covenant Care to: Mission, Ethics and Spirituality (name of recipient) in accordance with section 40(1)(d) of the *Freedom of Information and Protection of Privacy Act* ("FOIP") and/or section 34 of the *Health Information Act* ("HIA"), in the form of (check all that apply):

- ✓ Still/digital Photographs
- ✓ Sound recordings
- ✓ Video recordings (with or without sound)
- ✓ Writing
- ○ Other _____

for the following purpose(s) (check all that apply):

- ○ Media release/interviews
- ✓ Publications
- ✓ Education
- ✓ Promotions/ Advertising
- ✓ Social media
- ✓ Covenant Foundation
- ✓ Presentations
- ✓ Hospital displays
- ✓ Covenant Health website/intranet *(accessible nationally and internationall*
- ✓ Covenant Care website *(accessible nationally and internationally)*
- ✓ Other : Mission Awards website, Mission is… series, Compass Weekly, CovenantStrong.ca, Vital Beat

(Check and complete if applicable): I confirm that Covenant Health and/or Covenant Care may use my name, address and telephone number for the purpose of contacting me to discuss any changes in circumstances which may be relevant to the consent. My address and telephone number is as follows: _____

Email Address: _____

Other relevant information/conditions: _____

I acknowledge that I have been made aware of the reasons that my personal information (including a photographic image or images of myself) and/or individually identifying health information is needed and the risks and benefits of consenting, or refusing to consent, to the use and /or disclosure of the same. I understand and confirm that I may revoke this consent at any time.

I release and discharge Covenant Health and Covenant Care, and those for whom each is responsible at law, from all responsibility and liability for the content of the above mentioned still/digital photographs, video recordings and/or sound recordings and the specific use to which they may be applied. I declare that this release and discharge shall be binding upon my heirs, executors, administrators and assigns.

I understand that I have the right to refuse to grant this consent.

This consent is effective this _____ (day) day of _____ (month), 20 ____ (year) and (if applicable) expires on the _____ (day) day of _____ (month), 20 _____ (year).

_____
Signature of Staff or Patient or Authorized Representative

_____
Signature of Witness

_____
Printed Name of Staff or Patient or Authorized Representative

_____
Printed Name of Witness

_____
Source of Representative's Authority
(If applicable, attach copy of authoritative document)

Information on the form is collected under the authority of section 33(c) of FOIP to obtain your consent to disclose your information for the purpose(s) indicated above. For more information about the collection of information on this form contact the communications staff member working with you or call 780.735.7766.