



Northwell Health Release and Authorization to Record for Film, Video and/or Still Photography

**For internal use only*

Event/Purpose/Story:

I, _____, hereby authorize Northwell Health (formerly the North Shore-LIJ Health System), to record my picture, likeness, image and voice on film, video (digital or tape format) or still photographs; to edit the recordings at its discretion; and to incorporate the recordings into film or video productions or otherwise, and to use and license others to use such recordings, films, videos and photographs in any manner of media.

I further acknowledge that there were no promises of any compensation for such use by the health system and that Northwell Health exclusively owns all rights to these recordings irrespective of the form in which they are produced and used.

I represent that I have read and understand the contents of this Release and Authorization, and that I have the authority to sign this Release and Authorization.

Signature: _____ Date: ____/____/____

Print Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone/Cell: _____ Email: _____

If the above named is a minor (under 18 years of age) , authorization must be that of a parent/guardian

PARENT/GUARDIAN NAME

PARENT/GUARDIAN SIGNATURE

Address: _____

DATE: _____