

# CONSENT FOR USE OF PHOTOGRAPHS, AUDIO, OR VIDEO RECORDINGS FOR CLIENT USE



BAYADA Home Health Care has requested the use of my name, likeness, image, and/or voice, recorded on videotape, film, slides, photographs, audio tapes, or other media (referred to as "materials") for public use in internal and external company communications. Such communications include, but are not limited to: brochures, audiovisual presentations, advertisements, commercials, newspaper articles, magazines, books, internet and social media, websites, and any other form of printed or digital media.

**OWNERSHIP:** I understand that if the materials are copyrighted by BAYADA, the materials will be owned and under the control of BAYADA. I hereby release and discharge BAYADA and/or representatives from all claims arising out of the lawful use of the materials once such materials are released to the general public.

**COMPENSATION:** I understand that I will ***not*** be paid or compensated for the use of my photographs, audio, or video materials published by BAYADA.

**PRE-PUBLICATION REVIEW:** I understand that BAYADA will make all reasonable efforts to ensure that all materials will present me in a respectful manner. However, I am not required to view or approve these materials prior to publication.

**EXPIRATION:** This authorization expires ten years after the date of my signature unless I or my representative cancel or revoke it as defined below. (Expiration periods of one year apply in Maryland and Massachusetts.)

**REVOCAION:** I understand this authorization may be cancelled or revoked at any time. Cancellation or revocation must be made by me or my representative either via email to [photoconsents@bayada.com](mailto:photoconsents@bayada.com) or in writing and sent to: BAYADA Home Health Care, Marketing Office, 4300 Haddonfield Road, Pennsauken, NJ 08109. Once revoked, no new materials will be developed using your image, likeness or voice. However, BAYADA may continue to use existing materials until the supply is exhausted.

## AUTHORIZATIONS

**CLIENT:** I \_\_\_\_\_ (print name) am a **client or former client** receiving health care services from BAYADA. I have agreed voluntarily to participate in the activity of being photographed or recorded that will produce materials for use by BAYADA. I understand that I have certain privacy rights that are protected under state and federal law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand and accept all of the above conditions, and by signing this form, I am authorizing the use of such materials by BAYADA including my full name and diagnosis in all internal and external communications as permitted by state law.

\_\_\_\_\_  
Signature of client or client's representative      Relationship to client  
Date

Street address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email address: \_\_\_\_\_

Comments: \_\_\_\_\_ Client initials: \_\_\_\_\_

### For BAYADA Use Only

BAYADA representative: \_\_\_\_\_ Client #: \_\_\_\_\_ Office abbrev: \_\_\_\_\_

Initial purpose of photograph, recording, or video: \_\_\_\_\_  
(may be repurposed at a later date)

Expiration date (Calif. residents only): \_\_\_\_\_