



Cooper Norcross Health
Communications and Marketing Department
1 Federal Street, Camden, NJ 08103
Phone: 856.382.6463 Fax: 856.382.6499

Marketing Consent and Release Form

AGREEMENT FOR USE OF PHOTO, VIDEO, AUDIO, AND/OR INTERVIEW

I, (patient/individual - *please print name*) _____, grant The Cooper Health System ("Cooper Norcross Health"), its affiliates, agents, and those authorized by Cooper Norcross Health, the irrevocable right to record, photograph, publish, stream, broadcast, distribute, digitize, edit, reproduce, and use my name, image, likeness, voice, biographical information, video, photograph, interview, and any statements, including personal health information regarding any illness, injury, or treatment at Cooper Norcross Health (collectively referred to as the "Recording"). These materials may be used in any media now known or developed in the future (e.g., print, TV, radio, social media, websites, and other digital platforms) for marketing, advertising, public relations, or other promotional purposes, without limitation, worldwide and indefinitely.

I understand that I will not receive compensation for the use of the Recording and I waive any rights to royalties or review/approval of the final materials. I release Cooper Norcross Health and its affiliates from any claims, including defamation, privacy violations, or infringement of rights related to the use of the Recording.

I acknowledge that this authorization and release has no expiration date, but I may revoke this authorization at any time by notifying Cooper Norcross Health's Communications and Marketing Department, but that Cooper Norcross Health may still use or disclose my information, including my health information, if it has already been used or disclosed on the basis on this authorization. I further understand that I will not have the option to review or approve materials before they are used or published, and other media outlets may reprint or rebroadcast the Recording after its release.

This Agreement is governed by the laws of New Jersey and is binding on me, my heirs, and legal representatives. I confirm that I am over the age of 18 and I have read and fully understand the terms of this Agreement (or that my parent/legal representative has read and signed on my behalf).

Signature of Consenting Patient/Person

Signature of Patient Legal Representative

Date of Signing

Recording Date(s)

For Cooper Norcross Health Communications and Marketing Use Only:

Marketing/event description: _____

Location/facility: _____

Person/organization taking photo/audio/video: _____

Identifying elements (e.g., woman wearing pink shirt, nurse with glasses, outside on steps, etc.):
