



# Hospice of the Western Reserve

17876 St. Clair Avenue  
Cleveland, OH 44110

## MEDIA RELEASE FORM

- ▶ I / we, the undersigned, hereby consent to the **use of the name** of the individual below by Hospice of the Western Reserve, Inc., or its designees.

**Circle one:**                      **Yes**    **No**

- ▶ I / we, the undersigned, hereby consent to the making of **news articles, photographs, motion pictures, videotapes and audiotapes** of the person named below by Hospice of the Western Reserve, Inc., or its designees.

**Circle one:**                      **Yes**    **No**

- ▶ I / we understand that **the material will be used for editorial, news, educational and/or promotional purposes** to further the goals of Hospice of the Western Reserve. Material may also be used by other institutions or professional groups for education with authorization from Hospice of the Western Reserve.

**Circle one:**                      **Yes**    **No**

- ▶ I / we, the undersigned, hereby consent to the use of the name, images and story about the individual below on Hospice of the Western Reserve, Inc. **online** properties including, but not limited to the website (hospicewr.org) and/or any other social/digital media platforms. There is no time limit for use of the aforementioned materials.

**Circle one:**                      **Yes**    **No**

Check if signer is a patient.                       Check if signer is a family member.  
*If either box is checked a copy of this form is to be scanned into patient's EMR.*

***Please provide the required information below in full. (Do not leave any blank lines.)***

Name of individual \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to individual if not self \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

*Material used for:*