COLUMBIA UNIVERSITY MEDICAL CENTER
MEDIA AUTHORIZATION

- I have been asked to participate in the production of a health media initiative (the "program") which will be produced and distributed by any and all media (the "Producers");
- The Columbia University Medical Center ("CUMC") has permitted the Producers to record one or more segments of the Program at facilities maintained by CUMC; and
- As part of my participation in the production of one or more segments of the Program it will be necessary for the Producers and/or CUMC to use, simulate and portray my name, voice, likeness, picture, image, personality, personal identification information in connection with the production, distribution, promotion, advertising and exploitation of the Program.
- By reviewing and signing this Authorization, I grant to CUMC, and to any persons or entities authorized by CUMC ("CUMC Group"), the right to use, simulate and portray my Name in connection with the production, distribution, promotion, advertising and exploitation of one or more segments of the Program in all media and distribution channels of any kind, whether now known or hereafter devised.
- I acknowledge that I am agreeing to participate in this activity voluntarily and without compensation.
- Release and discharge the CUMC Group from any and all claims, demands or causes of action that I may now have or may hereafter have for libel, defamation, invasion of privacy or right of publicity, infringement of copyright or violation of any other right of mine arising out of or relating to any such use of my Name and Information in connection with the production, distribution, promotion, advertising and exploitation of one or more segments of the Program; and
- This Authorization expires twenty (20) years from the date hereof. I have a right to receive a copy of this Authorization.
- I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and sent or delivered to the following address: Attn: Office of Communications- Consent, Columbia University Medical Center, 701 West 168th Street, New York, NY 10032. My revocation will be effective upon receipt and will apply to any and all future uses. The revocation will not apply to any Program materials completed or distributed prior to receipt of my revocation.

Date: _____

Name: _____
(Please print)

Address: _____

Phone: _____

Signature: _____
Subject/Responsible Party

I*f signed by someone other than the subject, you must state your legal relationship*

to the subject: _____

WITNESS: _____