Boston Foundation for Sight
Release and Authorization

This shall authorize Boston Foundation for Sight to use my Protected Health Information under HIPAA law, the use of my personal likeness and my personal story and letter for news stories and articles, fundraising materials, brochures, campaign materials and any other media to publicize the work of the Foundation. I understand that I can revoke my permission at any time concerning releases that will take place at any future time from the receipt of my written request that my name, story, and likeness no longer be used. I grant my permission willingly, of my own free will, and without compensation of any kind.

Name:____

Date of Birth:___________________________________

Signature:______________________________________

Social Security No.:______________________________

Name of Parent or Guardian if under 18:

____

Signature of Parent or Guardian:____________________

Date:____