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If I/my child/my ward am a hospital patient:

I understand that this authorization is voluntary and there is no expiration date for this use of photographs/videotapes/audiotapes and information by TSRHC. Photographs/videotapes/audiotapes and information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and are no longer protected information.

I have the right to revoke this authorization at any time provided that it is in writing, except to the extent that TSRHC has taken action in reliance thereon. To revoke this authorization, I understand that I should send my revocation in writing to HIPAA Privacy Officer, Texas Scottish Rite Hospital for Children, 2222 Welborn Street, Dallas, TX 75219.

TSRHC may not and will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

Name of Child	Age	Date of Birth	City of Residence
Name of Child	Age	Date of Birth	City of Residence
Name of Child	Age	Date of Birth	City of Residence
Authorized Signature	Date	Relationship to Child/Children	