



**Adult HPCF Program  
Media Release Form**

This form *only* needs to be completed if the release section was not completed when submitting an application for the *Small Gift Program*. This form should *only* be submitted if a photograph or photographs will be submitted to the *Hospice & Palliative Care Foundation* for use in marketing materials. At the *Hospice & Palliative Care Foundation*, we respect the privacy of our patients, and therefore; we will never sell your information or picture (s), and we will never release your name in any of our marketing materials. **All photographs must be submitted to our general information email at [info@hpcfoundation.org](mailto:info@hpcfoundation.org).**

I, \_\_\_\_\_, grant the *Hospice & Palliative Care Foundation*, on  
(Patient's Name/Responsible Party)

behalf of \_\_\_\_\_, permission to use any photograph (s)  
(Patient's Name/Responsible Party)

submitted to [info@hpcfoundation.org](mailto:info@hpcfoundation.org) for any legal use, including but not limited to, publicity, copyright purposes, illustration, advertising, flyers or other printed materials, web content, and grant proposals. Furthermore, I understand that no royalty, fee, or other compensation shall be become payable to the patient or to my family by reason of such use.

Patient's Name (Print): \_\_\_\_\_

Physical Address of Adult Patient (Street, City, State, and Zip) (*No Post Office Box*):  
(Do Not Forget Extension i.e. Road, Street)

\_\_\_\_\_  
\_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Responsible Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Responsible Party Completing Forms: \_\_\_\_\_

Address of Responsible Party Completing Forms:

\_\_\_\_\_  
Street (Do Not Forget Extension i.e. Road, Street) City

\_\_\_\_\_  
State Zip Code Phone

Email: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_