PATIENT CONTENT QUESTIONNAIRE

Thank you so much for sharing your story with us. You can share your story in one of three ways:

- Type or write out the answers to the following questions.
- Record a voice memo on your phone of you answering the questions or simply sharing your experience.
- Record a video testimonial about your experience.

Please answer as many of the questions below as you feel comfortable. Be as specific as possible, including significant dates of diagnoses and hospital admissions.

- Include your name, phone number, email address and city where you live.
- Who is your health care provider (first and last name)? What Northside location did you visit?
- What was the reason you visited this provider? How were you referred?
- Share your journey / experience: What was your diagnosis? How did you react to the news (highs and lows)?
- What is your current treatment plan? How is it impacting your daily life?
- How has your recovery been?
- What is your health today?
- Please talk about your family / community and how they have supported you.
- Did you have a family history of disease or another condition that may have contributed to your diagnosis?
- What was your experience at Northside? How did staff support you?
- What do you do for fun?
- Is there anything you would like to share?

For Video Testimonials

- Please shoot horizontally (landscape orientation), and use something to keep your phone as steady as possible.
- Avoid using the zoom function or shooting into the light. Be sure that windows, overhead lights, etc. are behind the camera.

Consent Form

Email your responses, voice memo and/or video to media@northside.com along with a signed copy of the attached Consent Form. You can scan or take a photo of your signed consent and attach it to your email.

NON-EMPLOYEE PHOTOGRAPHY/VIDEO CONSENT FORM

NORTHSIDE HOSPITAL

Northside Hospital photographic consent and authorization to disclose protected health information for media or marketing purposes.

I authorize Northside Hospital or _____ to take photographs or videotapes of me (collectively "photographs"), and to use or disclose those photographs and other information about me, as specifically provided below. I understand that photographs may be considered "protected health information" subject to protection under the federal privacy regulations.

I authorize the individual or organization named above to use or disclose the photographs and other protected health information about me for the following purposes: *(please initial as applicable)*

_____ use in marketing material that is disseminated within and outside of the Hospital;
_____ use in press releases and articles disclosed to local or national media
_____ use in articles published in Northside Hospital publications
_____ use in articles or press releases referenced above that also are listed on the Northside Hospital web site and social media (e.g. Facebook, Twitter, Instagram)
_____ use in broadcast media (TV, radio, news or feature segments)
other: _____

The protected health information about me, other than the photographs, that may be disclosed, is:
(Please 'write "none" if no other information is to be disclosed.) personal interview, video and audio recordings

This authorization is subject to the following additional limitations:
(Please' write "none" if no additional limitations apply.) _____

This authorization to release the photographs or other protected health information about me shall remain valid for ten (10) years from the date of this authorization, unless otherwise noted.
(Please insert date or event when authorization will expire.) _____

I understand that I can revoke this authorization at any time by submitting a written revocation to:

If filmed by or on behalf of Northside:
Marketing & Public Relations Department
Northside Hospital
1000 Johnson Ferry Road
Atlanta, Georgia 30342

If filmed by or on behalf of another entity:
_____
_____
_____

I understand that revoking this authorization will have no effect on disclosures that have already occurred before my written revocation is received by the individual or organization named above. I also understand that once publications that include my photographs or other protected health information have been distributed, those publications cannot be withdrawn from circulation. I understand that once the photographs or other protected health information is released pursuant to this authorization, the information might be redisclosed and no longer protected by the federal privacy regulations. I understand that Northside Hospital will not receive any payment associated with use of this photograph or with release of any other protected health information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment at Northside Hospital.

_____ _____
Witness Signature of Patient or Legal representative

_____ _____
Date/ Time AM/PM Relationship to Patient if not the Patient