Gift-in-Kind Form

We request that all items be new and in original packaging. This helps to ensure infection control for our sick children. Please bring your gift to:

Peyton Manning Children's Hospital at St. Vincent
2001 West 86th Street • Indianapolis, IN 46260 • (Entrance 4)
Questions? Phone: 317.338.7193 • Email: elizabeth.ellis@stvincent.org

Please print clearly:

Date _____

This gift is from _____ ❍ Individual ❍ Organization ❍ School

Contact name (if applicable) _____

School name and grade(s) _____

Organization name _____

Address _____

_____

City _____ State _____ ZIP Code _____

Telephone number_____ Email address _____

Description of gift/donation *(please be specific)* _____

_____

_____

Estimated dollar value $ _____

How were these gifts collected? _____

Signature _____

Special reason for donation _____

_____

_____

Associate accepting donation _____

❍ Yes, I would like my donation to be to be considered for recognition on the hospital's social media.
(Please read and sign the media release on the back of this form).

Thank you for bringing smiles to children and for supporting Peyton Manning Children's Hospital at St. Vincent!

Peyton Manning Children's Hospital

St. Vincent

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16G INFORMED CONSENT

St. Vincent

MEDIA PARTICIPANT RELEASE AND AUTHORIZATION MARKETING COMMUNICATIONS

Patient ID

1. By signing below, I hereby transfer and grant St.Vincent Health, Inc. ("St.Vincent") the exclusive right to use and to authorize others, including but not limited to St.Vincent Health ministries and subsidiary organizations, to use all or any part of my interview/photograph/video or film likeness, regardless of medium by which it is recorded, in the program or marketing communication regarding: Marketing of donation to Peyton Manning Children's Hospital at St. Vincent

2. I further hereby transfer and grant to St.Vincent the exclusive right to use and authorize others to use all or any part of my interview/photograph/video in related media such as books, magazines, journals, pamphlets, electronic (Internet) and other written and video formats.

3. I also hereby authorize the release of my protected health information as more specifically described below: N/A.

4. I understand that the purpose of the use or disclosure shall be (please mark all that apply):
   ❑ External Educational Purposes ❑ Internal Educational Purposes ❑ Promotional Purposes
   ❑ News Media ❑ Internet ☒ All of the above

5. I understand that I may refuse to sign this Authorization. I understand that St.Vincent will not provide or withhold any of my medical treatment based on my signing or refusing to sign this form. I understand that I have a right to request the recording or filming stop. I understand I have the right to revoke this Authorization in writing at any time, except to the extent that St.Vincent has already relied upon this Release, or up to seventy-two (72) hours before the recording, film or publication is set to be used. Revocations of this Release should be sent to: St.Vincent Health, Inc. Marketing and Communications, 10330 North Meridian Street, Indianapolis, Indiana 46290.

6. I agree to indemnify and hold harmless St.Vincent, its directors, officers and agents, from any kind of loss, cost, damage, expense, attorney's fees, and liability. I understand that my Protected Health Information that is used or disclosed under this Release and Authorization may be subject to redisclosure by the recipient.

Printed Name of Participant: _____

Street Address: _____ Apt. No. _____

City: _____ State: _____ ZIP Code: _____ Tele. #: _____

Participant's Signature: _____ Date: _____

If participant is under 18 years of age, this form must also be signed by a parent or legal guardian.

Signature: _____ Date: _____

MEDIA PARTICIPANT RELEASE AND AUTHORIZATION – MARKETING COMMUNICATIONS