Authorization for Use and Disclosure of Protected Health Information For Marketing and/or Promotional Purposes

***This Form to be used in Conjunction with Form entitled "Consent for Use and Disclosure of Image, Voice and/or Written Testimonials"**

Facility: _____

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

_____

Social Security #:_____ Telephone: _____

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Type of information to be released: Video images, photographic images, conversations, sounds, audiotapes, verbal and/or written testimonials and statements, including biographical information, of the individual identified above.

Purpose of Request
To videotape, photograph and record audio of patients for the facility's marketing purposes, including but not limited to production of recordings, brochures, advertisements, videos and similar image and sound capture for purposes of publication and/or distribution via all types of media.

Payments to Facility
This marketing activity involves direct or indirect compensation/payment from a third party to the facility for this use of protected health information. ***Check One*: ☐ Yes ☐ No** _____ **Initials**

Persons Authorized to Receive Information
I agree that the publication and distribution of the protected health information described herein may and likely will include distribution of such information to the general public via various methods, including all types of media outlets (e.g., TV, radio, newspaper, Internet) for the facility's marketing purposes. I also understand that the facility may hire third parties to capture the image and/or voice of the individual identified above, and that my information will be used and disclosed by these third parties as instructed by the facility.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release
I understand that if any videotape, photograph or audiotape references drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.
Check One: **☐ Yes ☐ No** _____ **Initials**

Expiration & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at _____. Unless revoked, this authorization will expire on the following date or event: _____.

In the event that facility has relied on this authorization to create marketing and/or other promotional materials featuring my likeness (e.g., photographs or video), audiotapes of my voice, my name, my testimonial or recommendation and/or other information released pursuant to this authorization, I understand and agree that facility shall retain the right to use my likeness, voice, name, testimonial and/or other information until such time as all such marketing and/or promotional materials then in existence at the time of any revocation of this authorization are distributed, disseminated or expire. Any revocation of this authorization will become effective only after all marketing and/or promotional materials are distributed, disseminated or expire.

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by anyone receiving it, and the information disclosed will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that facility may not condition treatment, payment, enrollment, or eligibility for benefits for the individual identified above on whether I sign this authorization form. I may inspect or copy the protected health information to be used or disclosed. **I authorize the facility to use and disclose the protected health information specified above for the purposes set forth above.**

Signature: _____ Print Name: _____ Date: _____

Authority to Sign if not patient (e.g., parent, guardian): _____

Identity of Requestor Verified via**: ☐ Photo ID ☐ Matching Signature ☐ Other, specify** _____

Verified by Facility Employee (Signature): _____