

PUBLISHING AND BROADCASTING RIGHTS MEDIA RELEASE AUTHORIZATION

Patient Name:	
Provider:	
Media Project:	
Date of Filming:	

Why we are asking for your authorization:

The Health Insurance Portability and Accountability Act (HIPAA), effective April 14, 2003, requires your express permission before we may discuss/release your protected health information (PHI) to any third person to include your relatives, friends, employer, etc. Authorization is needed to document your intent, approval, and consent to discuss and/or release your PHI to any third person and also for you to identify the person(s) whom you give your Provider permission to release your PHI to (“authorized person”). As explained in our Privacy Notice, HIPAA does not require your authorization before we may share your PHI with health care providers (e.g., physicians, hospitals, etc.) involved in your treatment or payment for your treatment. This exception is to ensure uninterrupted business operations, such as timely submission and processing of your claims for medical benefits. Therefore, it is not necessary to name your health care providers as authorized persons.

This authorization for release of your PHI, which includes your likeness, is being provided because you are in agreement with, and are giving your consent, for us to film you while you are in our office and/or maybe in the process of receiving medical care from us while in our office. Although we will do our best to mask your identity, when and if any of the material filmed while you are present in our office is released publicly either in written, electronic, oral, or other visual or audio form, by using techniques such as blurring, pixelation, or voice alteration software in attempting to obscure your identity, your authorization is nonetheless required if we are to permit members of the media, including film crews, into areas of our facilities where PHI will be accessible in written, electronic, oral or other visual or audio form.

I _____ have been asked to participate in the production of a health media initiative (the “Program”) which will be produced and distributed by any and all media (the “Producers”). My Provider, _____ (“MY PROVIDER”) has permitted the Producers to film one or more segments of the program at facilities maintained by MY PROVIDER.

I agree to be photographed, interviewed, filmed, videotaped, and/or recorded by the Producers. As part of my participation in the production of one or more segments of the program, it will be necessary for the Producers and/or MY PROVIDER to use, simulate, and/or portray my name, voice, appearance, likeness, picture, image, personality, and statements made by me

(collectively, “my personal information”) in connection with the production, distribution, promotion, advertising, and exploitation of the Program.

I hereby consent and grant to MY PROVIDER and any persons or entities authorized by MY PROVIDER (the “MY PROVIDER Group”) and the Producers the irrevocable, perpetual and worldwide right and permission to use, reuse, copy, modify, alter, create derivative works, publish, perform, display, and transmit my personal information, whether recorded on or transferred to videotape, film, slides, photographs, audio tapes and recordings, electronic files, or other media, now known or later developed, in videotapes, audio and video recordings, internet postings or other web publications of the filmed, videotaped, and/or recorded likeness of me (collectively, my “Image”), alone or with other persons in any and all media and formats now existing or subsequently developed, in their sole discretion, for purposes of the Program.

I understand that the information used and disclosed will include my personal information, such as my name and other identifiable information, including that described in the HIPAA Authorization for Media Release Form and other information about my medical condition.

I waive any right I may have to inspect or approve any uses made of my Image in connection with this Release.

I agree to hold harmless and release MY PROVIDER from any and all claims, demands, or causes of action (collectively, “Claims”) that I or my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate, have or may have by reason of this Release, whether now or in the future, relating to the use of my personal information and Image in connection with the production, distribution, promotion, advertising, and exploitation of one or more segments of the Program in all media and distribution channels of any kind, including without limitation, any Claims for libel, defamation, invasion of privacy or right of publicity, infringement of copyright, or violation of any other right of mine. I further agree that any negatives, prints, or other material for printing or reproduction prepared in connection with the use of my personal information by the Producers shall be the sole property of the Producers or MY PROVIDER.

By signing below, I acknowledge that I have completely read and fully understand the above Release and agree to be bound by the terms described herein.

I certify that I am over the age of eighteen (18) years and have legal capacity to sign this form

Patient Name (print):	
Date:	
Signature (of patient or representative*):	
Address:	

Email:	
Phone Number.:	

*** Parent or other legal representative must sign if patient is under 18 years of age or legally incapable of consent. If signed by someone other than the patient (parent, guardian, or other legal representative):**

Name of Representative:	
Relationship to patient:	

HIPAA Privacy Authorization Form For Media Release

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

By signing this Authorization, I _____ hereby give permission for My Provider _____, its affiliates, business partners, and agents (together, “MY PROVIDER”) to disclose my personal information, including information about my medical condition, health treatment, and prescription drugs (collectively, “Health Information”) to any and all media (the “Producers”) for the health media initiative described in my signed Publishing and Broadcasting Rights Media Release Form (“Media Release Form”).

I understand that MY PROVIDER is not receiving payment from the Producers for participating in the health media initiative described in this form and in the Media Release Form.

I understand that I may refuse to sign this form and that if I do not sign it, I may not be permitted to participate in any aspect of the health media initiative.

However, my refusal to sign will not affect my ability to receive treatment from my health care provider, nor will it affect my payment, enrollment, or eligibility for health benefits.

I understand that there is the potential for information disclosed pursuant to this Authorization to be subject to redisclosure, and that it may no longer be subject to federal privacy protections.

I understand that I may revoke this Authorization at any time by writing to My Provider and requesting revocation of my continued participation in the Media Project from the date of my request onward but my revocation will not affect uses or disclosures of my Health Information previously disclosed in reliance upon this Authorization.

I understand that this Authorization will remain valid for one (1) year from the date I sign, unless I revoke it earlier.

I understand that I will receive a copy of this Authorization.

By signing this form, I acknowledge that I have read and accept all the above.

I certify that I am over the age of eighteen (18) years and have legal capacity to sign this form

Patient Name (print):	
Date:	
Signature (of patient or representative*):	

Address:	
Email Address:	
Phone Number:	

*** Parent or other legal representative must sign if patient is under 18 years of age or legally incapable of consent. If signed by someone other than the patient (parent, guardian, or other legal representative):**

Name of Representative:	
Relationship to patient:	