



**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
FOR MEDIA, PROMOTIONAL OR ADVERTISING PURPOSES**

Patient Name: _____

Previous Name, if applicable: _____

Email: _____ Mailing address: _____ City: _____ State: _____

Date of birth: _____ Home phone: _____ Work phone: _____ Cell Phone: _____

1. EMORY ENTITIES

I consent to and authorize Emory University or its affiliated entities (including, but not limited to Emory Healthcare, Emory University Hospital, Emory University Hospital Midtown, Emory University Orthopaedics & Spine Hospital, Emory Johns Creek Hospital, Emory Saint Joseph's Hospital, Emory Rehabilitation Hospital, Emory University Hospital at Wesley Woods, the Emory Clinic, Winship Cancer Institute, or Emory Wesley Woods Center [collectively "Emory"]) to use and/or disclose my health information for media, promotional, fundraising, and/or advertising purposes.

2. NATURE AND PURPOSE OF DISCLOSURE

The nature of my health information to be used and/or disclosed is diagnosis, treatment, and care related to disease and symptoms; genetic information and information derived from genetic testing and family medical history, including the results of genetic testing of family members, the manifestation of disease and symptoms in family members and requests for, and receipt of genetic and medical services and participation in clinical research which includes genetic services by the individual and the individual's family members.

Check One:

- I also specifically authorize representatives of Emory to discuss my health information described above for such media, promotional, and/or advertising purposes.
- This authorization does NOT authorize representatives of Emory to discuss my health information described above for such media, promotional, and/or advertising purposes.

3. CONSENT TO INTERVIEW

I consent to being interviewed, photographed, filmed, video/audio taped, and/or having my voice or image recorded by other electronic or non-electronic means by Emory, its employees, or such agents as it may engage for this purpose. I also authorize Emory to permit other individuals and entities, including but not limited to representatives of commercial or non-commercial newspaper, magazine, radio, or television related organizations, to interview, photograph, film, video/audio tape, and otherwise record me on any of the Emory premises. I further understand that during the course of any such interview, photographing, filming, recording or taping, my health information will be disclosed and, unless otherwise noted, I may be identified by name. I further consent to the distribution and publication of my name, interviews, photographs, films, video/audio tapes and other recordings via print, television, radio, electronic or any other means.

4. PUBLICATION

I grant Emory permission to use and/or disclose any such interviews, photographs, films, video/audio tapes and other recordings in Emory's own publications or in any other broadcast, print or electronic media, including without limitation newspaper, radio, television, magazine, Internet, or computer transmission. I further grant permission for any such interviews, photographs, films, video/audio tapes, and other recordings to be edited and/or incorporated into any compilation or derivative work as is deemed necessary or appropriate. I waive any right to inspect or approve my depictions in these works.

5. RE-DISCLOSURE

I understand that if my health information is disclosed to the media or the general public pursuant to this authorization, it is no longer protected by the federal privacy regulations. I further understand that once such materials are in the possession of the media or members of the general public, Emory does not retain control over their editing or use.

