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 (please specify disease/symptoms/therapies/diagnosis): _____
_____
_____

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.

6. EXPIRATION OF AUTHORIZATION

Unless I request in writing otherwise**,** I understand that this authorization will expire one-hundred (100) years from the date on which I signed this authorization.

7. RIGHT TO REVOKE AUTHORIZATION

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Emory Health Sciences Communications, 1762 Clifton Road, Suite 1000, Atlanta, GA 30322. I further understand that the revocation will not apply to any health information that has already been released in response to this authorization. For example, a revocation will not apply to any images, regardless of the format, which have already been created, published and/or distributed, but will apply to the publication and/or distribution of any future images created based on this authorization.

8. REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE

I understand that my refusal to authorize the use and/or disclosure of my health information for media, promotional and/or advertising purposes will in no way affect my eligibility to receive medical care at any Emory health care facility.

9. PATIENT COMPENSATION

I understand that this authorization is voluntary and that I will receive no compensation for the use and/or disclosure of my health information for media, promotional and/or advertising purposes. I further understand that I will have no economic and/or intellectual property right, title or interest, or any other property right or license in the interviews, photographs, films, video/audio tapes, and other recordings authorized above.

10. EMORY COMPENSATION

I understand that Emory ❑ will **✓❑ will not** receive financial compensation from a third party for the use and/or disclosure of my health information.

11. RELEASE AND WAIVER

If the health information I am disclosing contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), Venereal Disease, Tuberculosis, or Hepatitis or information derived from genetic testing, I hereby waive any privilege concerning such information for the purposes authorized above. I hereby release Emory University and its affiliated entities, including but not limited to Emory Healthcare, Inc., 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, or Emory Wesley Woods Center, and each of their trustees, officers, employees and agents, from any and all claims, liability, and damages, which might arise from the use and/or disclosure of the health information, or which might arise from the use of my name, interviews, photographs, films, video/audio tapes, or other recordings or images.

_____ _____

Signature of Patient (or Patient's Representative) Date

_____

Description of Authority to Act for Patient

NOTE: UPON REQUEST, A COPY OF THIS COMPLETED, SIGNED AND DATED FORM MUST BE PROVIDED TO THE PATIENT AND/OR PATIENT'S REPRESENTATIVE.

Name of Emory employee obtaining this signature_____