NYCHHC HIPAA Authorization to Disclose Health Information to the Media; for Marketing/Advertising, Fundraising, and Community Activities

NAME/ADDRESS OF PATIENT WHOSE INFORMATION WILL BE USED OR DISCLOSED	MEDICAL RECORD NUMBER	TELEPHONE NUMBER

NATURE OF RELEASE
Information will be released for the following purposes (please check all that apply):

- ☐ Media (including print, radio, television, and Internet)
- ☐ Advertising
- ☐ Training
- ☐ Marketing
- ☐ Fundraising
- ☐ Community activities
- ☐ Other (please specify)

PERSON OR ENTITY AUTHORIZED TO DISCLOSE THE INFORMATION

INFORMATION TO BE RELEASED
I authorize the disclosure of the following types of information (please check all that apply):

- ☐ **Specific Information** (please list and describe):
- ☐ Alcohol and/or Substance Abuse Program Information
- ☐ Mental Health Information
- ☐ Genetic Testing Information
- ☐ HIV/AIDS-related Information

NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE DISCLOSED

METHOD OF RELEASE
Information will be released in the following ways (please check all that apply):

- ☐ Interview
- ☐ Photograph
- ☐ Audio recording
- ☒ Other (please specify): Research/ Case report
- ☐ Film/videotape

For marketing disclosures only:

☐ I understand that NYCHHC will receive direct remuneration for the marketing of products or services related to this disclosure.

I authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that I do not have to sign this authorization. My refusal to sign this document will not impact my treatment, payment, enrollment in a health plan or eligibility for benefits in any way. However, if I do not sign this document, I understand that I will not participate in the activities indicated on this form.

I understand that NYCHHC and other organizations and individuals, such as physicians, hospitals, and health plans are required by law to keep my protected health information confidential. If I have authorized the disclosure of my protected health information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws.

I understand that I may change my mind and revoke this authorization so long as no action has been taken in reliance on my authorization. The revocation must be in writing, signed by me, and delivered to the Facility Public Affairs Director.

If I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient is prohibited from re-disclosing such information that I have authorized on this form unless permitted by federal or state law. I understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at 212.480.2493 or the New York City Commission on Human Rights at 212.566.5493. These agencies are responsible for protecting my rights.

If the information I agree to disclose relates to an Alcohol or Drug Abuse Program, Genetic Testing, Mental Health, and/or confidential HIV/AIDS-related information, I specifically authorize the information be disclosed to the person(s)/entity(ies) indicated on this form. I understand that additional form(s) may be required for the release of these categories of information.

I understand that this authorization will expire one year from the date indicated below, or on_____(date), whichever is later.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
DATE	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

A copy of this authorization must be provided to the patient/personal representative.
Contact Risk Management regarding law-related photo/recording/video requests.