# Patient Authorization for Marketing & Media Interview, Photograph and/or Videotape

As a patient of UC Health, I hereby authorize the disclosure of personal health information about me as a patient.

1. Describe fully the personal health information that is the subject of this authorization and which will be disclosed as written below (Ex: Name, Date of Birth, Illness, Symptoms, Condition, Treatment, Treatment Location, etc.)

   _____

2. UC Health may release my personal health information that is described above to the following media/educational outlets:
   - ◻ ALL marketing/communication needs
   - ◻ Advertising/marketing
   - ◻ UC/UC Health newsletters or magazines
   - ◻ Radio (specify) _____
   - ◻ Television (specify) _____
   - ◻ UC/UC Health websites
   - ◻ UC/UC Health social/digital media (Facebook, Twitter, etc.)

3. The purpose of the authorized disclosure of the information described above to the specific channels identified is as follows (Ex: media interview, educational production and/or photograph):

   _____

4. I understand that if the person/entity that receives the above protected health information is not a health care provider/health plan covered by federal privacy regulations, the protected health information described above may be re-disclosed by such person/entity and will likely no longer be protected by the federal privacy regulations.

5. I understand that I can ask that the photographing, recording or other imaging be stopped.

6. As described in the UC Health Notice of Privacy Practices, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by UC Health or UC Academic Health Center in reliance on this authorization, by sending a written revocation to UC Health, Marketing & Communications, 3200 Burnet Avenue, Cincinnati, OH 45229.

7. This authorization will expire five years from today, unless another date is requested by the patient. The expiration date will be _____.

8. I understand that I may refuse to sign this authorization form and that my refusal to sign will not affect my ability, or the ability of the patient identified above, to obtain treatment, payment or eligibility for benefits.

_____ _____

Patient Name Date of Birth

_____ _____ _____

Address Phone Number Email Address

_____ _____

Signature of Patient (Or Patient's Representative) Date

If signed by legal representative, relationship to patient: _____

***Legal representative must provide guardianship, executor of estate, power of attorney papers with this form*

_____ _____

Signature of UC Health or UC Representative Date

◻ Copy to Medical Records ◻ Copy to Patient ◻ Copy to Marketing and Communications

**For Marketing & Communications Use Only**

Marketing/Comm Representative: _____ Physician or Provider Name: _____

Service Line(s): _____ Treatment Location(s): _____

Photo/Video Shoot Location: _____