Patient Authorization for UW Medicine to Use or Disclose Protected Health Information for Publicity

Please read and complete the entire form in order for UW Medicine to process this request

I, _____ authorize the following UW Medicine entities:
Name

- ☐ Harborview Medical Center & Clinics
- ☐ UW Medical Center & Clinics – Northwest
- ☐ UW Medical Center & Clinics – Montlake
- ☐ Valley Medical Center & Clinics
- ☐ Hall Health Primary Care Center
- ☐ UW Medicine Sports Medicine Clinic
- ☐ UW Medicine Neighborhood Clinics
- ☐ University of Washington Physicians

to use or disclose protected health information for the treatment period beginning: ___/___/___ for publicity purposes. Publicity purposes may include: newspaper, radio, television, videotape, websites, and other published material.

Information to be used or disclosed:

I authorize the use of my image in photograph or video, my voice, name, age, sex, date of admit and discharge from a medical center if applicable, city of residence, general nature of injury/illness, condition, treatment and prognosis for publicity purposes.

Please withhold the following information*:* _____

Information may be used by or disclosed to:

- ☐ Media agencies or organizations *(such as TV and Newspapers)*
- ☐ UW Medicine Publications
- ☐ Other _____

I understand when I authorize UW Medicine to disclose protected health information about me to the media or for publicity purposes, media or organizations can re-disclose this information without my authorization.

Required Specific Release: ***(This must be completed)***

This authorization for release of records may include the release of the following specially protected information unless specifically excluded. Check appropriate boxes if you **DO NOT** want this information released:

- ☐ Reproductive care *(applicable to minors only)*
- ☐ Mental Health
- ☐ HIV/AIDS
- ☐ Sexually transmitted diseases
- ☐ Drug and alcohol treatment

Expiration of Authorization:

This authorization expires on _____ *(date)* **OR** when the following event occurs_____

(State when UW Medicine is no longer authorized to disclose my information based on this authorization. If no date or event is listed above, this authorization is valid for three years from the date on which it is signed.)

Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of one-year from the date signed by you.

Minors: A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care (2) sexually transmitted diseases *(if age 14 and older)*, (3) alcohol and/or drug abuse and mental health conditions *(if age 13 and older)*.

By signing this page, I acknowledge that I have read and agreed to the terms on both sides of this form.

Signature *(Patient Or Person Authorized To Give Authorization)*	Date
If Signed by Person Other Than Patient, Provide Reason, Relationship to Patient, Description of Their Authority	

PLACE PATIENT LABEL HERE

Authorization for UW Medicine to Use or Disclose Protected Health Information for Publicity

Potential for Redisclosure: Once your health information has been disclosed, the law does not always require the receiver of your information to keep it confidential.

Revocation: This authorization may be revoked by submitting a request in writing to:

UW Medicine Compliance
Box 358049
Seattle, WA 98195

Note: A request to revoke this authorization will not affect any actions already taken based on the original authorization, or prevent UW Medicine from requiring the information in order to be paid for treatment that you receive.

I understand I have the following rights to:

- Inspect or to receive a copy of my protected health information
- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected health information

I also understand UW Medicine will not base treatment or payment decisions on receipt of this signed authorization, except in these cases: (1) UW Medicine may condition research-related treatment on my signing or my providing an authorization for the use or disclosure of my information for such research **or** (2) UW Medicine may condition the provision of healthcare that is just for the purpose of creating protected health information for disclosure to a third party on my signing or my providing an authorization for the disclosure of the health information to such third party. An example of this is when a non-UW employer contracts with UW Medicine to conduct TB testing for purposes of employee health screening.

For Office Use Only:

Publicity	Names/Dates
1. Photograph	
2. Video	
3. Audio	
4. Interview with Patient	
5. Interview with Family	
6. Interview with Staff	
7. Other	
Completed by:	Date:

PLACE PATIENT LABEL HERE