

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
- University of Washington Medical Center & Clinics
- UW Medicine Neighborhood Clinics
- University of Washington Sports Medicine Clinic
- UW Medicine Eastside Specialty Center
- Hall Health Primary Care Center
- 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.

THIS FORM DOES NOT AUTHORIZE THE DISCLOSURE OF WRITTEN OR PRINTED MEDICAL RECORDS

Expiration of Authorization:

This authorization expires on _____ (date) OR when the following event occurs _____ (State when you want UW Medicine to stop disclosing information according to this authorization).

Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of 90 days from the date signed by you.

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	

PT.NO _____

NAME _____

DOB _____

UW Medicine
 Harborview Medical Center – UW Medical Center
 University of Washington Physicians
 Seattle, Washington

AUTH TO USE DISCLOSE PHI - PUBLICITY

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WHITE – MEDICAL RECORD
 CANARY - PATIENT
 PINK - DEPARTMENT

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POTENTIAL FOR REDISCLOSURE: Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information.

Revocation: I understand I may revoke this authorization by submitting the revocation request in writing to UW Medicine Privacy Office, Box 359210, Seattle, WA 98195, at any time. Any revocation will not be effective to the extent that action has already been taken based on the original authorization or where UW Medicine requires the information in order to be paid for treatment provided to me.

I understand I have the following rights: a) To inspect or copy my protected health information, b) To receive a copy of this signed authorization, and c) To refuse to sign this authorization.

I also understand UW Medicine will not condition treatment or payment based on receipt of this signed authorization, except (1) UW Medicine may condition research-related treatment on provision of an authorization for the use or disclosure of my information for such research **or** (2) UW Medicine may condition health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party; for example, 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:

PT.NO

NAME

DOB

UW Medicine
 Harborview Medical Center – UW Medical Center
 University of Washington Physicians
 Seattle, Washington

AUTH TO USE DISCLOSE PHI - PUBLICITY

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AUTHORIZATION - GRAY