AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION OBTAINED BY INTERVIEW, PHOTOGRAPH AND/OR AUDIO/VIDEOTAPE

Name: ____Phone: ____________________

Address: ____________________________________City: _________________State/Zip: _____________

Date of Birth: _____________________ Last 4 Digits of Social Security #: _________________

The protected health information ("PHI") I hereby authorize INTEGRIS Health and its affiliates to use and disclose, provided through my being photographed, audio/videotaped and/or interviewed for public relation purposes, will be limited to the following:

☐ My Name ☐ My Picture (Photograph)

☐ Occupation/Job Title ☐ My Voice (Recording/Audio)

☐ Life Events/Medical Story ☐ Video

☐ **All of the above** ☐ *Other (Please Describe)*: ____

I also hereby grant to INTEGRIS Health and its affiliates the right and permission to copyright and/or use, reuse, publish and/or republish the above indicated PHI for their public relation purposes. I hereby release, discharge and agree to hold harmless INTEGRIS Health and its affiliates from any liability resulting from use or disclosure of the above-mentioned information, my name, and/or photographic or audio/video images. I understand that I will have no control over the manner or use or distribution of materials, and hereby waive any right to inspect or approve any such use.

I understand my PHI is protected by federal regulations (42 C.F.R. Part 2 and/or 45 C.F.R.) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in INTEGRIS Health's privacy notice. 42 C.F.R. Part 2 prohibits redisclosure of information from alcohol and drug abuse patient records. However, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires INTEGRIS Health to notify me of the potential that information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by the HIPAA rules.

I hereby warrant that I am over 21 years of age and am competent to contract in my own name insofar as the above is concerned. (If person whose image and information is being used pursuant to this authorization is under 21 years of age, parent or guardian must sign below).

____

(Name of person and room number, if applicable)

The above information and images will be released to: ____

(Name of news organization/reporter/photographer)

Purpose of Disclosure/Story Topic: ________________________________

Unless revoked or otherwise indicated, this authorization will remain valid as long as INTEGRIS Health offers the service received. In the event INTEGRIS Health stops offering the service, this authorization will then expire.

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for thepurpose(s) listed.
- I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used ordisclosed. This authorization will expire twenty (20) years from the date I sign it unless I request an earlier expiration in writing.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment ofclaims.
- I understand, except as otherwise agreed upon pursuant to a separate written contract between the parties, I am not entitled to any royalty or payment of any kind in connection with the rights granted under this agreement.

Signature of Person: _____________________________ Date: _________________________

Signature of Person's Authorized Representative (if applicable) *: __________________________ Date: _____________

Relationship/Capacity of Representative: _______________________________________

Witness Name: ______________________________ Witness Signature: ________________________________

*Authorized Representative includes a parent or guardian of a minor or a legally appointed attorney-in-fact, health care proxy, or guardian of an adult.

A signed copy of this release should be kept on file.