Johnson Memorial Hospital jmmc

SAINT FRANCIS Hospital and Medical Center

Mount Sinai Rehabilitation Hospital

AUTHORIZATION FOR RELEASE OF INFORMATION

For Media/Public Relations, Fundraising and Marketing Purposes

I,____,____:

(PRINT PATIENT or LEGAL REPRESENTATIVE NAME) (DATE OF BIRTH OR LAST 4 DIGITS OF SSN)

authorize Saint Francis Hospital and Medical Center or Mount Sinai Rehabilitation Hospital or Johnson Memorial Hospital or any related affiliates to take photographs, films, audio and/or video, interview me, or publish article(s) or information about me for the purpose of:

- ☐ Hospital publications, fundraising, publicity, promotion, web site or advertising for Saint Francis Hospital and Medical Center or Mount Sinai Rehabilitation Hospital or Johnson Memorial Hospital or its affiliated entities.
- ☐ "Marketing" as defined in the Federal Privacy Regulations.
- ☐ Research/education programs.
- ☐ Publication and newspapers, printed media, radio, television, web and social media sites and all types of electronic communication media.
- ☐ Other: (specifically describe): ____

Briefly describe nature of project, including a specific description of what health/personal information will be involved, and the specific audience or type of audience that may be involved:

____

____

I consent to the taking and use of the photographs, films, audio and/or video, or publishing of the referenced article or information as described above for use by any Saint Francis Hospital and Medical Center or Mount Sinai Rehabilitation Hospital or Johnson Memorial Hospital or affiliate health care provider, i.e., reuse, unless otherwise indicated. I understand that I may be identified in any use of the above materials. I understand that I will not be compensated in any way for the taking or use of photographs, films, audio and/or videotapes, or the publishing of the attached article or information. I understand and agree that this Authorization is valid unless I cancel it in writing (as described in the next sentence) for as long as the Organization noted above (or any organization that succeeds it) stays in business. I understand that I may cancel this Authorization at any time (as long as the Organization noted above has not taken action in reliance on this Authorization) by mailing, faxing or taking a letter in person to the organization indicated above. I understand that once my private health information is used or disclosed, it is no longer protected by state or federal law.

I understand that neither Saint Francis Hospital and Medical Center or Mount Sinai Rehabilitation Hospital or Johnson Memorial Hospital or nor any of its affiliated health care providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I understand that if the Organization noted above will receive money or other compensation (either directly or indirectly) from someone else because of the use of my health information in the project described above, I have been told of the compensation. I agree that I have received a signed copy of this Authorization.

______________________________	______________________________	______________________________
Signature of patient, parent, guardian or legal representative	If minor, name of child	Date
______________________________	______________________________	______________________________
Street Address	Relationship, if patient is not signing	Witness
______________________________	______________________________	______________________________
City, State, Zip	E-Mail Address (internal purposes only)	Phone Number
______________________________		
Media Outlets(s)/Scheduled Date		