NEMOURS CHILDREN'S HEALTH

100228

Patient Name: _____

MRN: _____

DOB: _____

Authorization to Disclose Patient Photo/Video/Audio or Other Protected Health Information (PHI) for Publication:

Are you currently or have you ever been a patient of Nemours Children's Health? ☐ YES ☐ NO

1. I, (print name) _____, on behalf of the above-named patient, authorize Nemours Children's to USE AND/OR DISCLOSE the above-named patient's information and story with media outlets, social media channels and networks, advertising, websites, public marketing, promotional materials, fundraising, training and/or presentation and other similar venues. This form is not intended for the use of requesting copies of the patient's medical record. Such requests are to be directed to the local Health Information Management department.

☐ Lab results ☐ Imaging reports ☐ Diagnosis and treatment information	☐ Medications ☐ Patient photo/video/audio ☐ Other: _____	☐ Your initials are needed to release the following information: genetic testing information ____, Human Immunodeficiency Virus (HIV) tests results ____ and Sexually Transmitted Disease (STD) test results ____.

2. The following people and/or media organizations will have access to the PHI authorized in #1 above:

_____

_____

3. This authorization will expire:
   - ☐ On a specific date (if checked, enter the date) _____
   - ☐ After the completion of the following event/service/project _____
   - ☐ 10 years from date this form is signed

I understand that:

- Nemours Children's will not condition treatment on whether I authorize the requested use or disclosure.
- I can change my mind and revoke this authorization, in writing, at any time, by sending a written revocation to the Nemours Children's Privacy Officer at 10140 Centurion Parkway North, Jacksonville, Florida 32256.
  - If Nemours Children's has already used or disclosed the protected health information described above, then the revocation will only be valid for future uses or disclosures.
- Information used or disclosed may be redistributed by the recipient and may no longer be protected by Federal or state confidentiality law.
  - It is common that disclosures for broadcast or publication will include posting the materials onto web, social media or similar sites. Once this occurs your information will be publicly available and freely distributed.
- I have the right to inspect or copy the protected health information to be used or disclosed, as permitted under Federal law (or state law, to the extent the state law provides greater access rights).
- I will receive a copy of this Authorization.

Signature of Patient or Legal Representative	Date	Time (A.M. P.M.)
Print Name of Patient or Legal Representative	Email Address	
Relationship to Patient	Home Phone #	Cell Phone #

To be completed by associate:

Purpose of photo/video: _____

Situation in photo/video: _____

Patient's gender ☐ Male ☐ Female ☐ Nonbinary ☐ Prefer not to answer

Patient description in photo/video (hair color, clothing): ____

_____

Name of staff person: _____

Department: _____

Location: _____

Specific location in hospital or clinic in photo/video: _____

Date photo/video taken: _____

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