AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION TO NEWS MEDIA AND TO GENERAL PUBLIC
(Media Authorization Form)

We understand that information about you and your health is personal and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to communicate with the news media and the general public as described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form. A representative of SUNY Downstate Medical Center is available to answer any questions regarding this authorization.

Patient Name: _____ MR#:_____

Address: _____

_____

DOB: _____ Telephone #: _____ (Day) _____ (Eve)

I authorize that a statement/interview, and/or photograph, and/or illustration, and/or video, and/or movie, and/or audio recording may be taken of me by SUNY Downstate Medical Center (and/or its agents) or by members of the news media regarding my personal and medical history, condition(s), and treatment(s) for the purposes of publicizing, promoting, marketing, or advertising SUNY Downstate Medical Center's activities, programs, and services.

I grant permission for the above-described material(s), which may include Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA), to be used by news media, including professional medical or healthcare journals, for publication, and/or broadcast, and/or distribution via other means to the general public, not excluding its use at professional meetings, symposiums, poster sessions or other events. I recognize that the precise manner in which the information and material(s) may be used will be determined solely by the aforesaid media and I therefore acknowledge that SUNY Downstate Medical Center has no control over or responsibility for the use of such information and material(s).

I further grant permission for SUNY Downstate, at its option, to use the information and material(s) as it sees fit in publications and or productions of its own making and distribution.

Person(s)/ Organizations at SUNY Downstate providing the information: _____

The information may be disclosed to and used by the (*name of media outlet*) _____

Information to be disclosed: _____

I understand that I may be identified by name in connection with the public use of the information and material(s).

I hereby release and agree to indemnify SUNY Downstate and its affiliates, successors and assignees and their respective employees, trustees and agents from and against any and all liability, including reasonable attorneys' fees, arising out of the exercise of the rights granted by this authorization.

I understand that SUNY Downstate __ will __ will not receive direct or indirect remuneration as a result of this authorization.

This authorization expires on _____.

I understand that expiration of this authorization will not cause the aforesaid news coverage or promotional, marketing, or advertising materials made as a result of this authorization to be withdrawn from public circulation at the time of expiration or any time thereafter.

New York State regulations [NY Public Health Law §2782(1)(b)] require a special authorization for release of information regarding mental health, any HIV- related condition (including HIV-related test, illness, AIDS or any information indicating potential exposure to HIV) or drug and alcohol abuse.

__ Do not authorize release of this information.
__ Authorize release of this information.

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information.
If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from re-disclosing any HIV-related information without your authorization, unless permitted to do so under federal or state law. If you experience discrimination because of the release of disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.
You have a right to refuse to sign this authorization. Your healthcare, the payment for your healthcare and your healthcare benefits will not be affected if you do not sign this form.
You have a right to receive a copy of this form after you sign it.
You have the right to revoke this authorization at any time, except to the extent that action has already been taken based upon your authorization. To revoke this authorization, please write to:
SUNY Downstate Medical Center
Office of Institutional Advancement, Box 2
450 Clarkson Ave., Brooklyn, NY 11203

Signature: _____ Date: _____
(Participant, Personal Representative or Legal Guardian)

Witness: _____ Print Name: _____

Personal Representative or Legal Guardian: [Print Name] _____

Authority: _____ Telephone: _____

Address: _____