Authorization for Use and Disclosure of Protected Health Information including Photographs for External Purposes

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 obtain your authorization before we use or disclose your protected health information including statements/interviews, photographs, illustrations, videos, and audio/visual recordings for external purposes as described below. This form provides that authorization and helps us properly inform you of how this information will be used or disclosed. Please read the information below carefully before signing this form. A representative of Baylor Scott & White Health is available to answer any questions regarding this authorization.

I, _____ (PRINT NAME), authorize that a statement/interview, and/or photograph, and/or illustration, and/or video, and/or audio/visual recording may be taken of me by Baylor Scott & White Health, its affiliates, assignees, contractors and employees (collectively, "BSWH") or by another individual or entity for use by BSWH or members of the news media regarding my personal and medical history, condition(s), and treatment(s) for external purposes including but not limited to publicizing, promoting, educating, marketing, or advertising BSWH'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) and relevant state of Texas laws, to be used by BSWH or by news media, including but not limited to newspapers, television, radio, magazines, advertising, BSWH publications or video productions, the Internet, social media websites, 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 including but not limited to websites, live video presentations, taped video presentations, etc. I recognize that the precise manner in which the information and material(s) may be used will be determined solely by the aforesaid media, websites, journals, meetings, etc. and I therefore acknowledge that BSWH has no control over or responsibility for the use of such information and material(s).

I further grant permission for BSWH, 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.

I acknowledge that this Consent is not a commitment by BSWH to use the photograph, video, recording or interview obtained with this Consent and that BSWH reserves the right not to use the photograph, video, recording or interview. I hereby relinquish any right, title or interest in such photographs, videos, recordings or interviews, and to any control over their use, and to any proceeds that may arise therefrom. I acknowledge that I will not receive any compensation for such photographs, videos, recordings or interviews. I hereby release and forever discharge and agree to hold harmless BSWH from any and all liability arising from the photograph, video, recording or interview and/or any use by BSWH of the photograph, video, recording or interview. I also acknowledge that BSWH may conduct a background check on me using publicly available records.

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

I hereby release BSWH and its affiliates and employees from and against any and all liability arising out of the exercise of the rights granted by this authorization.

BSWH will receive direct or indirect remuneration as a result of this authorization. [Cross out if not applicable.]

If there are restrictions, please list _____

_____

Initials _____ Date _____

Person Photographed, Videoed, Recorded, Interviewed or Legally Authorized Representative

BSWH will not release any HIV-related information, including related tests, illnesses, diagnosis, or potential exposure.

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. I understand that I may revoke this authorization by providing the BSWH Office of Corporate Compliance, 2001 Bryan Street, Suite 2200, Dallas, TX, 75201, a written request stating my intent to revoke the authorization.

I understand that once my PHI is used and/or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s) and no longer protected by applicable laws.

This authorization expires in ten (10) years from the date on this form (including after death). I understand that expiration of this authorization will not cause the aforesaid news coverage or promotional, marketing, video, 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.

Print Name _____ Date of Birth _____
Person Photographed, Videoed, Recorded, Interviewed

Street Address _____ City _____ State _____ ZIP _____

Home Phone _____ Business Phone _____ Cell Phone _____

Email Address _____

Signature _____ Date: _____ Time: _____ A.M. / P.M.
Person Photographed, Videoed, Recorded, Interviewed or Legally Authorized Representative

Printed Name of Legally Authorized Representative _____

Relationship to Patient _____

BSWH Facility/Department _____ Room Number _____

BSWH Representative _____
Print Name *Signature* *Phone*

Marketing & Public Relations Representative (if applicable) _____ Date _____
Print Name

FOR INTERNAL USE ONLY

Media Outlet/Representation _____

Purpose/Information Release _____

Patient's Physician/Spokesperson _____ Title _____