UNC HEALTH

Authorization for Education, Fundraising and Marketing / Public Relations Purposes - Photo, Video and Other Protected Health Information (PHI)

HIM# 739s

Patient's Name (print)				*Date of Birth*
Patient's Address	*City*	*State*	*Zip*	*Phone #*

I AUTHORIZE THE RELEASE OF MY PHI FROM:

Name of UNC Health Hospital, Clinic or UNC Physicians Network Clinic that may release my PHI:

I AUTHORIZE THE RELEASE OF MY PHI TO:

(*check the purpose for the release, then describe the intended use of PHI and print name of the entity and/or individual that will receive PHI with contact information listed for the entity and/or individual.***)**

☐ **Marketing Public/Relations**: If the purpose of the release is for Marketing/Public Relations

Describe *marketing/public relations activities*:

_____

_____

Print name and contact information of individual or department performing marketing services:

_____

☐ **Fundraising**: If the purpose of the release is for fundraising:

Describe fundraising activities: _____

_____

_____

Print name and contact information of entity performing the fundraising activity:

_____

☐ **Education**: If Release is for educational purposes**:**

My PHI may be used for education offered or directed by my UNC Health physician or provider in any format or forum which may include but not be limited to publication in written or online media, books or journals, classroom instruction and/or medical training at UNC Health or other educational institutions, and/or at local national and global conferences or other professional or educational events.

Print name and contact information of physician and/or department that will receive PHI:

_____

IF RELEASE IS FOR EDUCATIONAL PURPOSES A COPY MUST BE SENT TO UNC HEALTH HIM DEPARTMENT FOR PLACEMENT INTO THE PATIENT'S CHART.

INFORMATION THAT CAN BE RELEASED: If specific dates only, list dates: _____

☐ Name ☐ Address ☐ **Video and/or photograph(s) of me which may include my face and images or video of procedures or treatment I have received**	☐ Testimonials ☐ Diagnosis ☐ Treatment Information ☐ Prognosis ☐ Physician or care giver's name(s)	☐ Name of facility, hospital or clinic where treatment was received ☐ Other (describe in detail): _____ _____ _____ _____ _____	**I further authorize the release of the following information which may be included in my PHI:** ☐ Mental Health/Psychiatric Treatment ☐Alcohol or Substance Abuse Treatment ☐ STD/HIV/AIDS Treatment(s) or Test(s) ☐ Genetic Testing

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I will not receive remuneration for releasing my PHI for the purpose(s) listed above.
I hereby release UNC Health and its affiliates and employees from any and all liability that may arise from the release of my PHI as authorized by this form.
I have the right to revoke this Authorization at any time if I do so in writing and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this Authorization.
I may refuse to sign this Authorization, and I cannot be denied or refused treatment if I refuse to sign and my refusal to sign this Authorization will not affect my treatment, payment, enrollment or eligibility for benefits or the quality of care I receive.
Once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy laws and could be re-disclosed by the person or agency that receives it.
This Authorization shall not have an expiration date and shall remain in effect unless and until I provide my written revocation made to the UNC Health office, facility or health care provider listed above.

My signature below indicates that I am giving permission for the use and disclosure of the PHI described above.

Signature of Patient	*Date*	*Time*
OR Signature of Authorized Representative	*Date*	*Time*
Printed Name of Authorized Representative	*Phone Number of Authorized Representative*	
Explain Representative's authority to act on behalf of the Patient:		