

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION SPECIFICALLY PHOTOGRAPHS/FILMS/VIDEOS

\_\_\_\_\_ (covered entity) may disclose protected health information in the form of photographs, films, and/or videos from the records of \_\_\_\_\_ (patient name).

The reason(s) for this authorization (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Education of other patients or physicians   | <input type="checkbox"/> The physician requests the information for marketing purposes.                                     |
| <input type="checkbox"/> Other (specify each purpose) _____<br>_____ | <input type="checkbox"/> The physician will get something of value for providing health information for marketing purposes. |

Initial one:  
\_\_\_\_\_ I agree and authorize the above-mentioned physician to place my photo, film, or video on his/her professional Web site.  
\_\_\_\_\_ **I DO NOT** authorize the use of these photos, film, or video on any Web site.

\_\_\_\_\_ I understand that the images will not be identified by name but that such photographs, videotapes, computer images, and/or Internet images may reveal my identity. I accept this loss of anonymity.

\_\_\_\_\_ I understand that I have the right to revoke this authorization, *in writing*, at any time by sending such written notification to the practice at \_\_\_\_\_ (office mailing address).

\_\_\_\_\_ I understand that a revocation is not effective to the extent that my physician has already disclosed the health information.

\_\_\_\_\_ I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment).

\_\_\_\_\_ I understand that information released by this authorization may be disclosed by the recipient and may no longer be protected by federal and state law.

\_\_\_\_\_ I further understand that photographs placed on the Internet become part of the public domain and may be modified or used for unintended or unanticipated purposes including for commercial gain.

\_\_\_\_\_ I understand this authorization ends:  on (date) \_\_\_\_\_  
 when the following event occurs \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date/Time

\_\_\_\_\_ copy given to patient/legal representative  
initials

\_\_\_\_\_ original placed in medical record  
initials