TULANE UNIVERSITY MEDICAL GROUP

HIPAA AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION FOR MARKETING, PUBLIC RELATIONS AND EXTERNAL COMMUNICATIONS

I authorize **Tulane University Medical Group** to use and/or disclose health information about

_____
(Patient's Name)

for promotional, educational and informational purposes to local, state and national government officials; reporters for local, state and national media publications, including newspapers, magazines and on-line media; and to reporters for local, state and national television broadcast stations, or as otherwise specifically described:

_____

_____

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information:

____ Appearance/interview by media on camera; still photos or video footage for use in publications (print or electronic), web sites, audio, video, television commercial, advertising or film.

____ Other health information to be used or disclosed: _____

_____

I understand that :

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have an effect on any actions taken prior to receiving the revocation. Further details may be found in the Tulane University Medical Group Notice of Privacy Practices.
4. If the receiver is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may have a copy of this form after I sign it.

This authorization will expire one year after the date below, or sooner by my choice (in which case this consent will expire on _____).

SIGNATURES	
I have read the above and authorize the disclosure of the protected health information as stated.	
Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient: