ST PETER'S HEALTH PARTNERS

Albany NY 12208

PATIENT/RESIDENT/CLIENT CONSENT
FOR RELEASE OF INFORMATION

Authorization for St. Peter's Health Partners to Use or Disclose Information for Videotaping, Filming, Photography, Marketing and News Media Coverage

I, _____("Patient/Resident/Client"), hereby authorize St. Peter's Health Partners ("SPHP"), its employees and agents, to use and disclose to the following medical information about me ("protected health information"):

❒ My name, face, voice, performance, video or film image.
❒ My personal written or oral statement about my treatment at SPHP.
❒ Personal health information, including treatment I am receiving, or have received at SPHP.

The purpose of this authorization is for me to permit the use and disclosure of the items listed above including any protected health information in the following manner.

❒ Promotional Brochure (for general public)
❒ Billboard (for general public)
❒ Advertisement (for general public)
❒ Video (for St. Peter's employees and general public)
❒ Other: _____
(insert communications vehicle and audience)
❒ Newsletter (for St. Peter's employees and general public)
❒ News Media (for general public)
❒ Social Media

This Authorization will expire on: _____

Patient/Resident/Client (P/R/C) hereby acknowledges that he/she understands that treatment, payment, enrollment in any health plan, or eligibility for benefits is <u>not</u> conditioned on his/her signing of this Authorization. P/R/C may refuse to sign this Authorization if he/she so chooses. P/R/C may inspect or copy the protected health information to be used or disclosed.

P/R/C has been informed and understands that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information, and, at that point, the information may no longer be protected under the terms of this agreement.

P/R/C hereby irrevocably releases to SPHP, all of his or her rights, ownership, and claims for the use of his or her name, face, voice, performance, video or film image in any manner whatsoever that he or she may have performed as talent in any announcement or publication produced by and for SPHP. This release is good worldwide in perpetuity beginning with the first date of publication.

The P/R/C hereby waives any right to compensation for the uses and disclosures authorized by this Authorization. The P/R/C and his or her successors or assigns hereby hold SPHP, its employees, other persons participating in the P/R/C's care, and its or their successors and assigns harmless from and against any claim for injury or compensation resulting from the uses and disclosures authorized by this Authorization.

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At all times, P/R/C retains the right to revoke this Authorization by sending a written notice of revocation to SPHP's Privacy Officer at 315 S. Manning Blvd, Albany, NY 12208. The revocation shall be effective *except* to the extent that SPHP has already used or disclosed information in reliance on the Authorization.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT/RESIDENT/CLIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT/RESIDENT/CLIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

Date: _____ Time _____AM/PM

_____	_____
Signature of Patient/Resident/Client	Please print name Date/Time
_____	_____
Signature of witness	Signature of person signing on behalf of Patient/Resident/Client *
_____	_____
Please print name Date/Time	Please print name Date/Time

*Please explain representative's relationship to Patient/Resident/Client and include a description of representative's authority to act on behalf of Patient/Resident/Client.