E-mail address: _____ Phone: _____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

INSTRUCTIONS: Complete each item below. The patient or the patient's Legal Representative must sign this completed Authorization before any information will be used or disclosed.

Patient Name:_____ MRN:_____
First Middle Last

Address:_____ Date of Birth: _____

I hereby give USA Health Office of Marketing and Communications the right to use/disclose, copyright, reproduce, and publish the Protected Health Information and/or material about me for release to the media and other parties as specified below.

I am granting permission for the following entities (Entity(ies)) to use/disclose my health information:
❑ USA Health ❑ University of South Alabama

I am granting permission for the following health information to be used or disclosed:
❑ name ❑ medical condition ❑ contact information ❑ photographs ❑ videotapes
❑ other information from my medical record as described here:

_____

My Protected Health Information may be used/disclosed for the following purposes (Check all that apply):
❑ interview ❑ photographs/video ❑ statistical/profile information ❑ promotional
❑ educational ❑ legal ❑ medical ❑ other: _____

I further authorize the use/disclosure of my Protected Health Information to (Recipient):

_____

Name of person, class of persons, facility, agency, or individual to receive information:

_____

Address

_____
City State Zip Code

In the event that any information is used for external media, I understand that USA Health Office of Marketing and Communications may share my information, making it possible for a media representative to contact (Check all that apply):
❑ me ❑ my family ❑ my physician ❑ an Entity(ies) representative(s) ❑ Other:_____

I ❑ do ❑ do not authorize USA Health Office of Marketing and Communications, the Entity(ies), or the above-mentioned Recipient to use ❑ my name or ❑ my name and family in conjunction with the authorized release of my Protected Health Information.

I understand that I will not receive any compensation if my photograph, likeness, or other information about me is released and/or used. I further understand that any photographs or videotape is the property of USA Health Office of Marketing and Communications and the Entity(ies) and may be used in future videotape or print projects as described in this Authorization.

My Protected Health Information may be disclosed as described in this Authorization for five (5) years from the date of this document.

I understand this Authorization can be revoked in writing at any time. The revocation shall be effective except to the extent that Entity(ies) has(have) already used or disclosed information in reliance on the Authorization. I may revoke this Authorization by writing to the USA Health Marketing and Communications, 2451 University Hospital Drive, Mastin Professional Building – 6th Floor, Mobile, AL 36617. I hereby acknowledge that I understand treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information and may no longer be protected under the terms of this agreement.

I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION AS STATED ABOVE.

_____
Date

_____
Signature of Patient or Legal Representative and Relationship to Patient

If patient is unable to sign, secure authorization of Legal representative and indicate reason below:
❑ Minor ❑ Incompetent ❑ Deceased ❑ Other

_____
Signature of Witness (USA Health Representative)

OTHERS COVERED UNDER THIS RELEASE:

_____

USA HEALTH