Authorization for Creation and Release of Patient Information, Interviews, Images, and Video/Audio Recordings

This form must be executed whenever a patient photograph, videotape, other visual or audio image, or interview is sought to be created, or when a patient's condition or other protected information is to be discussed with a third party, for any purpose **other than treatment, payment, or health care operations.**

I authorize LifeBridge Health, its subsidiaries, and affiliates (including the Save-A-Limb Fund) to interview my health care providers, my family members, and me and to create photographs, videotapes, and sound recordings of me.

I grant to LifeBridge Health, its subsidiaries, and affiliates (including the Save-A-Limb Fund) the right to use such interviews, photographs, videotapes, and sound recordings; x-rays and other information from my medical record and other information concerning my condition (including protected health information); and other materials provided by me (such as photographs, videos, and my personal story) for such patient education, marketing, promotional, and other purposes as they deem appropriate, including but not limited the presentation of such items or extracts thereof to media representatives and their placement on web sites and in brochures and other marketing materials.

I authorize my health care providers to discuss with media representatives and others information regarding my medical condition; information contained in my medical record, including protected health information; and other materials provided by me.

I hereby release and hold harmless LifeBridge Health, its subsidiaries and affiliates (including the Save-A-Limb Fund), and their officers, directors, employees, and agents from any and all liability arising from, or associated with, the creation, release, publication, or use of such materials.

I also understand that:

1. I do not have to sign this authorization and my refusal to sign will not affect my right to obtain treatment from the facilities and providers of LifeBridge Health.
2. I have the right to revoke this authorization at any time. My revocation must be in writing and delivered to the Practice Manager. However, my revocation will not be effective with respect to materials that have already been published, disseminated, or otherwise disclosed pursuant to this authorization.
3. I have a right to inspect and copy my own protected health information in accordance with the requirements of the federal privacy protection regulations found at 45 CFR §164.524.

I certify that I have received a copy of this authorization. This authorization will expire one year from the date written below unless terminated sooner by me. Please note that once material has been disseminated or posted, the use of this material may continue beyond the one-year authorization.

Patient Name: ______________________________ Date of Birth: ______________

Condition(s): ______________________________ Physician(s): ______________

______________________________ ______________
Signature of Patient or Personal Representative — Date

______________________________ ______________
Printed Name of Patient or Personal Representative — E-mail Address

______________________________ ______________
Signature of Witness — Date

____
Printed Name of Witness

White Copy - Medical Record *Yellow Copy - Marketing/Practice Manager* *Pink Copy - Patient*

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