AUTHORIZATION FOR UW SCHOOL OF DENTISTRY TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR PUBLICITY

PLEASE READ AND COMPLETE THE ENTIRE FORM IN ORDER FOR UW SCHOOL OF DENTISTRY TO PROCESS THIS REQUEST

I, _____ authorize UW School of Dentistry to use or disclose protected health information for the treatment period beginning: _____ for publicity purposes. Publicity purposes may include: newspaper, radio, television, videotape, websites, and other published material.

Information to be used or disclosed:

I authorize the use of my image in photograph or video, my voice, name, age, sex, date of treatment if applicable, city of residence, general nature of injury/illness, condition, treatment and prognosis for publicity purposes.

Please withhold the following information: _____

Information may be used by or disclosed to:

- ☐ Media agencies or organizations (such as TV and Newspapers)
- ☐ UW School of Dentistry Publications
- ☐ Other: _____

I understand when I authorize UW School of Dentistry to disclose protected health information about me to the media for publicity purposes, media or organizations can re-disclose this information without my authorization.

THIS FORM DOES NOT AUTHORIZE THE DISCLOSURE OF WRITTEN OR PRINTED PATIENT RECORDS

Expiration of Authorization:

This authorization expires on _____ (date) **OR** when the following event occurs _____ (state when you want UW School of Dentistry to stop disclosing information according to this authorization).

Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of 90 days from the date signed by you.

By signing this page, I acknowledge that I have read and agreed to the terms on both sides of this form

SIGNATURE (PATIENT OR PERSON AUTHORIZED TO GIVE AUTHORIZATION):

DATE SIGNED:

IF SIGNED BY PERSON OTHER THAN PATIENT, PROVIDE REASON, RELATIONSHIP, DESCRIPTION OF THEIR AUTHORITY:

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*POTENTIAL FOR REDISCLOSURE***:** Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information.

Revocation: I understand I may revoke this authorization by submitting the revocation request in writing to UW School of Dentistry Compliance, Box 356365, Seattle, WA 98195, at any time. Any revocation will not be effective to the extent that action has already been taken based on the original authorization or where UW School of Dentistry requires the information in order to be paid for treatment provided to me.

I understand I have the following rights: a) To inspect or copy my protected health information, b) To receive a copy of this signed authorization, and c) To refuse to sign this authorization.

I also understand UW School of Dentistry will not condition treatment or payment based on receipt of this signed authorization, except (1) UW School of Dentistry may condition research-related treatment on provision of an authorization for the use or disclosure of my information for such research **or** (2) UW School of Dentistry may condition health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party; for example, when a non-UW employer contracts with UW Medicine to conduct TB testing for purposes of employee health screening

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FOR OFFICE USE ONLY:

PUBLICITY	NAMES/DATES
1. PHOTOGRAPH	
2. VIDEO	
3. AUDIO	
4. INTERVIEW WITH PATIENT	
5. INTERVIEW WITH FAMILY	
6. INTERVIEW WITH STAFF	
7. OTHER	

COMPLETED BY: _____ DATE: _____