Patient 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 admit and discharge from a medical center 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 or for publicity purposes, media or organizations can re-disclose this information without my authorization.

Required Specific Release: (This must be completed)

This authorization for release of records may include the release of the following specially protected information unless specifically excluded. Check appropriate boxes if you DO NOT want this information released:

- ☐ Reproductive care (applicable to minors only)
- ☐ Sexually transmitted diseases
- ☐ Mental Health
- ☐ Drug and alcohol treatment
- ☐ HIV/AIDS

Expiration of Authorization:

This authorization expires on _____ (date) **OR** when the following event occurs_____(State when UW School of Dentistry is no longer authorized to disclose my information based on this authorization).

Minors: A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care (2) sexually transmitted diseases (if age 14 and older), (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older).

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
If Signed by Person Other Than Patient, Provide Reason, Relationship to Patient, Description of Their Authority	

Authorization for UW School of Dentistry to Use or Disclose Protected Health Information for Publicity

Potential for Re-disclosure: Once your health information has been disclosed, the law does not always require the receiver of your information to keep it confidential.

Revocation: This authorization may be revoked by submitting a request in writing to:

UW School of Dentistry Compliance
Box 356365
Seattle, WA 98195

Note: A request to revoke this authorization will not take affect any actions already taken based on the original authorization, or prevent UW School of Dentistry from requiring the information in order to be paid for treatment that you receive.

I understand I have the following rights to:

- Inspect or to receive a copy of my protected health information
- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected health information

I also understand UW School of Dentistry will not base treatment or payment decisions on receipt of this signed authorization, except in these cases: (1) UW School of Dentistry may condition research-related treatment on my signing or my providing an authorization for the use or disclosure of my information for such research **or** (2) UW School of Dentistry may condition the provision of healthcare that is just for the purpose of creating protected health information for disclosure to a third party on my signing or my providing an authorization for the disclosure of the health information to such third party. An example of this is when a non-UW employer contracts with UW to conduct TB testing for purposes of employee health screening.

---

*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:

Patient Name:
Patient Account Number:
DOB: