MedStar Health

Authorization for Use and Disclosure of Protected Health Information

Photo, Interview and Media Consent Form

Please complete the following information:

Patient/Visitor Name: _____ Date of Birth: _____

Address: _____

City, State, ZIP: _____ Phone: _____

I hereby authorize MedStar Health and its affiliates and agents to take photographs or produce videotapes, audiotapes, electronic files, or other types of media productions that capture my name, voice and/or image, to be released to members of the media, or to be used by MedStar for the purpose of:

- News media (online, print and/or broadcast)
- Publications and/or promotional materials
- Closed circuit television programs
- Advertisements
- Websites and social media
- Medical and/or educational training
- Any other lawful purpose

The information to be disclosed includes (check all that apply):

☐ Photographic images of me
☐ Video or audio of me and/or my voice
☐ Images from records such as scans and/or X-rays
☐ Information about my medical condition and/or prognosis
☐ Information about date(s), time(s) and type(s) of treatment received
☐ Other _____

I understand that once my information is disclosed, it may be re-disclosed for MedStar-approved uses by third parties. I further understand that this authorization is voluntary, without compensation, and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or receive payment from my insurance company. It will also not affect my eligibility for benefits. I understand by signing this form I represent and warrant that I have authority to sign this document, authorize the use or disclosure of protected health information and declare there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

This authorization shall remain in effect for 12 months from the date below and shall automatically renew for additional one year periods until such time as you notify MedStar Health of your intent to revoke this authorization. You may provide such notice by sending your written request to **MedStar Health, Public Affairs and Marketing, 10980 Grantchester Way, Fifth Floor, Columbia, MD 21044**.

_____ _____
Signature of patient/visitor or patient's/visitor's legal representative Date

_____
Printed name of patient/visitor or representative

If signing as a representative, please indicate your relationship to the patient/visitor: ☐ Parent ☐ Guardian ☐ Power of attorney

This portion is to be completed by a MedStar Health representative.

_____
Signature of MedStar Health representative

_____
Date

_____
MedStar entity name

Purpose of photo and/or interview (provide details):