Patient/Student Information Authorization for Release Through News Stories, Photography, and News Media

Date:_________

Story Topic:____

Faculty/Student(s) in story:____

Patient Name (Print):____

Patient Address/City/ST:____

Patient Phone Number:____

I grant my full permission to USF Health and/or the news media to use, or to arrange for the use of, my or my child's protected health information including my medical condition or treatment, for a news story, photography, video/film/audio recordings. I hereby waive all rights of privacy or compensation, and any other claims in contract or tort, which I may have in connection with the production of such materials and disclosure of my protected health information.

I have been informed of the context and usage of my information or image and the type of news reporting to be taken. I acknowledge that I voluntarily give my permission and waive my rights of confidentiality.

I understand that I may refuse to sign this form. I understand that I am not required to sign this Authorization form in exchange for receiving treatment from the University of South Florida. I also understand that payment, enrollment in a health plan, and/or eligibility for benefits will not be conditioned upon my signing this form.

I may revoke this authorization form at any time by notifying the USF Health Office of Public Affairs at the address and phone number listed below, of my intent to revoke this authorization. However, I understand that such revocation will not have any effect on any information already used or disclosed to news media by USF Health before the University received my written notice of revocation.

This authorization form expires one year from this date, or when I revoke it. I understand that my Protected Health Information may be **re-disclosed by the news media** and no longer protected by federal or state privacy laws.

I understand that the information released will include my medical information related to my **mental health records/treatment.**

Signature of Patient or
Authorized Representative:________________________________ Date:________

If signed by person other than patient/student, provide reason/relationship ________________________________

Witness signature:____

USF Health Public Affairs • University of South Florida

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