UAB and UAB Medicine Enterprise

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT INFORMATION for UAB/UAB MEDICINE MARKETING AND COMMUNICATIONS

I hereby authorize the use or disclosure of my protected health information ("PHI") as described below. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and no longer be protected by federal privacy regulations.

Patient Name: _____ **Patient Birthdate:** _____/_____/_____

Patient Address: _____

Patient's Phone: (_____) _____ **City, State, Zip:** _____

This authorization is for the purpose of sharing your health care story in writing, in photos, and/or in a video recording including, but not limited to, past health care provided to you, your current health care encounters, your appreciation to your providers and the staff, and your interactions with your health care provider(s), to be used for activities in support of UAB/UAB Medicine Marketing and Communications. These activities could involve all types of electronic and non-electronic media including, but not limited to, letters, announcements, newsletters, presentations, posters, and videos. Additionally, this authorization gives permission to your UAB/UAB Medicine physicians or other health care providers to disclose your information relevant to your story.

You will personally disclose your story to UAB representatives who will prepare it for use by UAB/UAB Medicine Marketing and Communications for the purposes indicated above.

The patient or the patient's representative must read and initial the following statements:

Initial:_____ I understand that I have a right to revoke this Authorization at any time by notifying UAB Medicine's Chief Privacy Officer in writing. If I do, I understand that revocation will not affect the information that has already been released in response to this Authorization. The Chief Privacy Officer can be reached at 205-996-5051.

Initial:_____ I understand that UAB/UAB Medicine may not condition the provision of treatment, payment, and enrollment in a health plan or eligibility for benefits on signing this Authorization.

Initial: _____ I understand that I, and my heirs or next-of-kin, surrender all rights and privileges to all negatives, prints, audio recordings, and/or video recordings mentioned above, as well as all current and future rights to UAB/UAB Medicine for these marketing and communications purposes.

This Authorization will expire when UAB/UAB Medicine discontinues its use of my story.

Signature of patient or patient's representative: _____

Printed Name of patient: _____

Printed Name of patient's representative: _____

Relationship of representative to the patient: _____

Date: _____

For office use only:

- This form is to be used if specific health information will be received directly from a UAB/UAB Medicine physician, other health care provider, or staff. OR
- The individual providing the consent/authorization is someone other than the patient to whom the information belongs.