FOR STAFF USE ONLY:

Patient's printed name: _____ Location: _____ Date: _____

Story or project:_____ Photographed by: _____

Authorization for Release of Information for Promotional Purposes

Marshall University Joan C. Edwards School of Medicine University Physicians & Surgeons, Inc./Marshall Health/PROACT

I, _____ , voluntarily give my permission for the following medical and health information to be used or disclosed by Marshall University's School of Medicine, University Physicians & Surgeons/Marshall Health (Marshall/UP&S) and PROACT. Check all those that **do** apply:

- ❑ Photographs or video recordings of me while I am on the premises of Marshall/UP&S
- ❑ Medical or health information, including my name, address and specific information about my injuries, treatment or medical condition
- ❑ Information pertaining to my participation in substance use disorder treatment programs, including, but not limited to, 'Part 2 Programs' as defined by 42 C.F.R. Part 2, which may include my name and photographs taken in connection with this authorization.
- ❑ Other information described here: _____

The information will be used or disclosed by Marshall/UP&S/Marshall Health/PROACT for news stories, articles, publications, brochures, journal publications, newsletters, advertisements, promotional videos, social media posts, website-related uses and other public relations purposes. Marshall/UP&S/Marshall Health may disclose the information to any news and television media included, but not limited to the following:_____.

I acknowledge that I am waiving my rights to confidentiality of the above information by signing this authorization. I understand once materials are released to the media, Marshall/UP&S/Marshall Health/PROACT have no further control over their use or redisclosure. **I also understand that once information is released in any form it might be re-released and no longer protected by federal patient privacy rules.**

I understand that if I have authorized the release of information that identifies me as someone that has or has had a substance use disorder, then I am waiving certain rights under federal law that provide heightened protections to patient information pertaining to substance use disorder, known in some instances as 'Personally Identifiable Information' under 42 C.F.R. Part 2. I expressly direct that such information be provided to the person or persons within University Physicians & Surgeons, Inc., PTOACT or the Joan C. Edwards School of Medicine for purposes of generating promotional materials consistent with this authorization. I authorize my name and likeness to be used for promotional purposes. I may choose to provide a testimonial or other written documentation that is not contained within my patient record, and, if I choose to do so, expressly authorize such person or persons to publish and make use of such writing.

I understand that I am not required to sign this authorization, and that if I am a patient, I will receive treatment even if I do not sign it. I understand that I may revoke this authorization at any time. To do that, I must say so in writing and give or send it to the Director of External Affairs or the Privacy Officer. I understand the revocation will not apply to information that had already been released while the authorization was in effect and that any person may rely on this authorization until I revoke this authorization. Written revocation should be sent to: Director of External Affairs, Marshall University Joan C. Edwards School of Medicine, 1600 Medical Center Drive, Huntington, WV 25701.

This authorization will be in effect until further notice but in no event longer than reasonably necessary to accomplish the purpose of the authorization..

Patient/Legal representative signature: _____ Date: _____

Relationship, if not patient: _____

Address: _____

Email: _____ Phone number: _____

Witness signature: _____ Date: _____

Name of witness (please print): _____