Media Authorization for the Use and Disclosure of Protected Health Information

I, _____ (print name) the undersigned, authorize the use and/or disclosure of my protected health information ("PHI") as described below:

1. I authorize Baylor Health Care System and its affiliated covered entities, and the members of their medical staff and allied health staff ("Baylor") to disclose to media representatives, production companies, advertising agencies, photographers and/or public affairs staff members PHI and information about me, my condition or treatment for purposes of publicity, advertising, marketing, promotion, education or publication in print, broadcast and electronic media. This authorization includes my likeness on photo, videotape and digital media. My authorization applies to my entire record or is limited to the information described below. If designated below, only this PHI may be used and/or disclosed pursuant to this authorization:

_____

_____

I ACKNOWLEDGE AND HEREBY CONSENT TO SUCH, THAT THE RELEASED INFORMATION MAY CONTAIN ALCOHOL, DRUG ABUSE, PSYCHIATRIC, HIV TESTING, HIV RESULTS OR AIDS INFORMATION. _____ **Initial**

FOR Baylor All Saints Medical Center at Fort Worth PATIENTS:

I authorize Baylor All Saints Medical Center at Fort Worth to release the health information described herein to:

Name/Title of Person or Organization_____

Address_____

Phone Number_____ Fax Number_____

2. This authorization expires in 10 years.

3. I understand that once my PHI is used and/or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s) and no longer protected by applicable privacy laws.

4. I acknowledge that this authorization is not a commitment by Baylor to use my PHI for purposes of publicity, advertising, marketing, promotion, education or publication in any manner or media and that Baylor reserves the right not to use my PHI.

5. I understand that I have the right to revoke this authorization at any time. My revocation must be in writing as described in the Notice of Privacy Practices. I am aware that my revocation is not effective to the extent that I have authorized the use and/or disclosure of my protected health information and such use and/or disclosure have been relied upon by authorized recipients. To revoke this authorization, I must notify Baylor's Public Relations department at: 214-820-3055.

6. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Baylor nor will it affect my eligibility for benefits.

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____

Printed name of person signing the document

_____

WITNESS SIGNATURE DATE

If signed by a personal representative, describe what authority you have act on behalf of the person whose information is being released: _____