SR0735
Rev. 10/16

DukeHealth

Name_____

Contact Info_____

Physician_____

Keywords_____

DUKE HEALTH ENTERPRISE AUTHORIZATION TO USE AND/OR DISCLOSURE PROTECTED HEALTH INFORMATION FOR DUKE COMMUNICATIONS, MEDIA RELATIONS AND EDUCATIONAL PURPOSES

I _____, am the patient or legal authority (circle one) to authorize Duke University, Duke University Health System, the Private Diagnostic Clinic and other members of the Duke Health Enterprise identified in its Notice of Privacy Practices (collectively "Duke"), as well as any duly authorized affiliates, subsidiaries and physicians to use, disclose, store and archive the materials and health information of (patient name) _____ described below to the public for the activities and purposes described below:

Specific materials and health information to be used, disclosed, stored or archived for the public activities and purposes identified below:

☐ Demographic information such as name, age, city/county and state of residence

☐ Specific diagnosis and treatment information, including treatment date(s), provider name(s) and treatment location(s)

☐ De-identified medical images, photos, scans

☐ Exceptions or special instructions:_____

I agree to participate, or permit my providers or other staff to participate, in an interview; to have photographs and/or audio and video recordings taken; and that these materials and any other health information identified above may be used, disclosed, stored or archived for the public activities and purposes marked below:

☐ For all purposes listed below

☐ News media, including television, newspapers, radio and their related websites and social media channels

☐ Duke physician marketing, including print and electronic materials

☐ Duke consumer marketing, including Duke websites, social media, YouTube and print materials

☐ Duke community relations, development, or promotional purposes

☐ Duke training, education, or medical illustration

Duke approved third-party commercial instructional or health educational materials of
_____(name of third party)

Notes or special instructions: _____

I understand that once the materials and health information identified above are publicly used or disclosed as provided in this authorization, Duke may not retain control over the further use or disclosure of these materials and health information by any third party, including other people, entities and media, and also that these materials and information may no longer be protected by federal or state privacy law. In particular, I understand that, after publication and/or distribution, these materials and health information may be picked up, reprinted and/or rebroadcast and disclosed by other people, entities and media who are not connected to Duke.

Duke cannot limit the amount of time the media may use footage for future print or online publications or broadcast, rarely has final control over the use or (re)distribution of such materials, and cannot guarantee that other entities will not capture and display on their own Web site or other communications media information that I have authorized to be disclosed by Duke above, despite Duke's copyright.

I understand that I will receive no compensation from Duke for this authorization or for anything described herein. I also understand that my health care treatment or payment for health care services at Duke is not conditioned upon my giving this authorization. I have read this form and fully understand the contents. I agree to be bound by this authorization. I acknowledge and represent that I am the patient whose health information is the subject of this authorization and that I am 18 years of age or older or that I am the personal representative of the patient whose health information is the subject of this authorization.

This authorization for Duke's purposes expires at the termination of the last of the activities described above in which I have agreed to participate. Specifically, the termination date occurs at the conclusion of the last activity that includes the above described materials and my health information.

I may revoke this authorization at any time, which I must provide in writing and send to _____. I understand this revocation will not affect any uses or disclosures prior to such revocation. I understand I may review or obtain a copy of the health information subject to this authorization by making a request in writing and sending it to the address above.

_____ _____ _____
SIGNATURE of Patient / Personal Representative DATE TIME

_____ _____
PRINTED NAME RELATIONSHIP to PATIENT

A signed copy of this form will be provided to patient or personal representative at the time of execution.