Authorization to Use and Disclose Protected Health Information (PHI) For Media/Marketing and Other Related Purposes

I authorize UCR Health to release my protected health information to (specify the name(s), the following news organizations or other outlets:

By signing this Authorization, I understand and agree that:

1. UCR Health may use my protected health information for the following purposes:

- ☐ Marketing (e.g. brochures, billboards, other advertisements about UCR Health Services)
- ☐ News Media/Documentaries (e.g. TV, newspapers, magazines)
- ☐ A media or entertainment consultant to obtain understanding of healthcare activities
- ☐ Other (specify) _____

2. The following types of protected health information may be used or disclosed by UCR Health:

All of the following
Name
Street Address, City and State
Phone Number
E-mail Address
Date of Birth/Age
Photograph/Video Image
Personal Story
Diagnosis/Method of Treatment
Date(s) of Treatment
Other

3. Once UCR Health disclosed my health information to the general public, including members of the news media or others who may widely distribute this information, UCR Health cannot guarantee that these recipients will not re-disclose my health information to others. Recipients of my protected health information may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

4. I may refuse to sign or may revoke (at any time) this Authorization for any reason and that refusal or revocation will not affect the commencement, continuation or quality of my treatment at UCR Health.

5. This Authorization will remain in effect until the term of this Authorization (as set forth below) expires or I provide a written notice of revocation to UCR Health Information Management Office at the address listed in Paragraph 6 below. The revocation will be effective immediately upon receipt of my written notice, except that the revocation will not

have any effect on any action taken by UCR Health in reliance on this Authorization before it received my written notice of revocation.

6. If I have questions regarding this Authorization, or the use of my protected health information, or if I desire to revoke this authorization, I may contact UCR Health, Health Information Management Office: By telephone: (951) 827-3257. By mail: UCR Health, Compliance and Privacy Office, 900 University Avenue, Riverside, California 92521.

TERM:
This Authorization will remain in effect:

From the date of this Authorization until the termination of the following fund-raising or marketing campaign:
Until (date) _____
Other:

_____

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize UCR Health to use or disclose my health information in the manner described below.

Signature of Patient _____
Date_____
Print Name (Last)
_____(First)_____(Middle)_____
Home Address _____

Home Telephone _____Date of
Birth_____/_____/_____

If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Personal Representative
_____Date_____
Printed Name of Personal Representative
_____
Description of Authority
_____ (Relationship to patient)