Staff Name _____

BROWNHealth UNIVERSITY

☐ RIH ☐ TMH ☐ HC ☐ BH ☐ NH ☐ BHMG ☐ GH

☐ Interview ☐ Video ☐ Photography ☐ Broadcast

Date_____

Community Authorization and Release
For Photography/Audio and Videotaping/ Broadcasting/Interviewing
(Not for patient use)

Initial use_____
name of brochure, ad, event, etc

Physical description_____
use if multiple patients photographed for initial use, ex. yellow shirt, tall, etc.

Name (please print):

Address (city/state/zip): _____

As applicable and as further described below, **I authorize** Brown University Health and its affiliates to photograph, video and/or audiotape, and/or interview me, or I agree to take part in any radio or TV programs (the "Permitted Interaction"). Describe nature of Permitted Interaction (i.e. context of interview, event at which photos are to be taken, etc.) and nature of information to be gathered:

I authorize the Brown University Health Marketing and Communications department to (1) identify me by name in any photographs, videos and/or audio tapes, interviews, broadcasts and/or news stories, generated from the Permitted Interaction, and (2) to use or disclose such materials (along with my name) for display in print, radio, TV or internet media or other form of media for advertising, marketing, promotional and educational purposes (the "Permitted Use"), and (3) to use and disclose such materials as necessary to effectuate the Permitted Use (i.e. to employees of newspapers or radio stations).

I authorize Brown University Health to copyright any photographs, videos and/or audiotapes, interviews, broadcasts and/or news stories, generated from the Permitted Interaction.

I understand that, to the extent the content of the Permitted Interaction contains my protected information, this information is protected under the federal privacy laws and regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

I understand that if the person or entity that receives my protected health information (as applicable) is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore I release Brown University Health from all liability arising from this disclosure of my health information.

I understand this authorization will expire ten (10) years from the date signed below. Prior to the expiration date, I understand I may revoke this authorization by notifying, in writing:

Brown University Health Marketing and Communications
117 Ellenfield Street, Suite 100
Providence, Rhode Island 02905

I understand that any previously disclosed information would not be subject to my revocation request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits at Brown University Health.

This form must be fully complete before signing.

Signature of Person or Person's Legal Representative

Date

Print Signer's Name

If authorization is related to a patient story, please list signer's relationship to patient and name of patient.

(A copy of this signed form will be provided to the signer).

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