

Attachment B

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MEDIA* PURPOSES (* media includes print and broadcast use, not limited to photography, videotape, audio recording, interview, publications)

I authorize the release of Protected Health Information about me or the person whom I am authorized to represent to LSU Health Sciences Center--- (*designate facility*) for media purposes, as specified below:

Type of Media: (check all that apply)

television radio Telemedicine newspaper internal publication
academic journal clinical teaching website
 other (explain _____)

No Payment Involved

I understand that I will receive no payment or remuneration for my agreement to participate in the media activities checked above. I also understand that by signing this form, I transfer all rights and claims regarding photography, videotape, audio recording, interviews, and publications that I may have now or in the future to LSU Health Sciences Center.

Treatment is Not Affected

I understand that LSUHSC may not condition treatment at any of its facilities upon the signing of this form.

Right to Revoke

I understand that I can revoke this authorization at any time, unless LSUHSC—(designate facility) has already relied on it, by writing to the facility Privacy Officer at [location & mailing address]. Unless revoked, this authorization will expire on the following date or event : five (5) years from date of signature.

Redisclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient Information:

Patient Name: _____

Date of Birth: ____/____/____

Address: _____

Telephone #: (____) _____

Information To Be Released – Covering the Periods of Health Care:

From (date) ____/____/____ To (date) ____/____/____

Must Give A Copy of Signed Authorization to Patient

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Type of Information to be released:

Drug or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Check One: Yes No Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Check One: Yes No Initials

Signature of Patient or Personal Representative

Signature: _____

Date: _____

Authority to Sign and Relationship, if personal representative:

Parent of minor legal guardian Power of Attorney
 other (specify _____)

*****INTERNAL USE ONLY*****

Identity of Personal Representative verified via: Photo ID Matching Signature on file
 Legal Documents (specify _____)
 Other (specify _____)

Verified by: _____