Attachment A
MEDIA RELEASE

Must Be Accompanied By a completed Authorization Form (Attachment B) Signed by the Patient

RELEASE 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-New Orleans 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-NO 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 in writing at any time, unless LSUHSC-NO has already relied on it, by writing to the facility Privacy Officer at 433 Bolivar St Room 811, New Orleans, LA 70112. Unless revoked, this authorization will expire five (5) years from date of signature.

Redisclosure

I understand the information disclosed by this release 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.

_____ Date ___/___/____

Signature of Patient or Representative

If Representative, Relationship to Patient _____

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 Media Release to Patient

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