

Authorization for Use/Release of Information/Photography

**TO BE FILLED OUT BY MINISTRY STAFF**

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Witness Name and Title *please print* Witness Signature Date

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Patient MRN/ID Number Patient Street Address City/State/Zip

* Local, state and/or federal policymakers
* Researchers or educators

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient Name, *please print*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_\_ – \_\_\_\_\_\_\_\_\_\_\_

Birthdate Phone Number

1. Person(s) authorized to use/disclose. I permit any authorized representative or agent of Trinity Health and its affiliates to share my identity and protected health information, including related interviews, images, quotes, comments and videos internally, for educational or business purposes, or externally, for advertising, marketing, social media, public relations, public affairs or similar activities. Specific projects include:

*Describe expected project(s) here, for instance, "Baby Friendly Nursery Campaign," "April News Conference," CEO interview/presentation, etc.*

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1. I understand that other individuals, organizations or businesses may receive my information either directly or indirectly and that they may share it with their own audiences. I further understand that Trinity Health and its affiliates have no control over such reuse of my information. Recipients may include:
* Public audiences
* Journalists, media outlets and/or their representatives
* Other health care and/or government organizations

1. If there is any information you prefer us not to share, please describe it here:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Compensation. I understand that I will not be compensated in any way for participating in this agreement or for the use of my image, quotes, comments or information.

5. I authorize the storage, reuse and re-disclosure of the information described above — and for the purposes described above — for one year from the date signed. I understand that I can cancel this authorization in writing, or in person, any time and that the cancellation will prevent all future disclosures by Trinity Health and/or its ministries. I can cancel my authorization at any time by calling the department holding the signed documents and verifying my identity, but I understand this request is only legally binding if I cancel my authorization by mailing, faxing or taking a letter and proof of my identity in person to the ministry that initiated this authorization. I also understand that a representative of Trinity Health or one of its affiliates will contact me to authorize any other or further uses of my information.

6. Statement of Understanding. I understand that neither Trinity Health nor any of its affiliates can require me to sign this authorization as a condition of getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan.

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Signature of Patient or Patient Representative Relationship to Patient Date

**RHM LOGO HERE**