Cincinnati Children's® Hospital Medical Center
cincinnatichildrens.org

Authorization and Release for the Use and/or Disclosure of Protected Health Information for Marketing and Communications

I authorize Cincinnati Children's Hospital Medical Center to use or disclose specific information (described below) about

☐ my ☐ my child's ☐ or (give relationship_____) medical condition.

The protected health information to be used or disclosed is described in detail below.

Patient Information (Please Print)

_____

Last Name *First Name* *Middle Initial*

_____

Address *City* *State* *Zip Code* *Phone*

Please check/specify the following type of information which you agree to be used or disclosed according to this authorization and the purpose for the use or disclosure:

☐ Protected Health Information (detailed below) to be used or disclosed as a story in a Cincinnati Children's publication (print or electronic), the Cincinnati Children's web site, audio, video, television commercial or film.

☐ Photographs to be used or disclosed in Cincinnati Children's publications (print or electronic), video, advertising or film for marketing/public relations purposes.

☐ Protected Health Information (detailed below) to be disclosed to the news media.

Please describe the Protected Health Information to be used or disclosed: _____

_____

_____

I hereby authorize the use and disclosure of the Protected Health Information to the purpose and extent stated above. This Authorization will expire five years after the date below, or sooner by my choice (in which case this consent will expire on _____). All Authorizations for disclosure of Protected Health Information to the media shall expire 60 days after the date below, or sooner by my choice (in which case this consent will expire on _____).

This Authorization may be revoked at any time to the extent that use or disclosure has not already occurred prior to your request for revocation. Please refer to the Cincinnati Children's Notice of Privacy Practices. In order to revoke the authorization, the patient/parent/legal guardian must notify the Cincinnati Children's Department of Marketing and Communications in writing at MLC 9012, 3333 Burnet Avenue, Cincinnati, OH 45229 or by telephone at 513-636-4420.

Cincinnati Children's will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The Protected Health Information used or disclosed as a result of this authorization may be subject to redisclosure by the person or entity receiving such information, and thus is no longer protected by the federal privacy regulations.

The photos or images specified above become the property of Cincinnati Children's or its representatives.

This Authorization is given without promise of compensation. The parent/legal guardian and the patient release to Cincinnati Children's any right, title and/or interest of any kind they may have in the information or images produced.

By signing below, I authorize Cincinnati Children's Hospital Medical Center to use or disclose any medical information specified in this Authorization.

Signature:_____**Date:**_____

☐ Patient ☐ Parent ☐ Legal Guardian

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization. If Cincinnati Children's requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.