Stanford University

AUTHORIZATION to Use or Disclose Protected Health Information For Publication and Educational Purposes

Patient Name (print name)	*Date of Birth*	*Phone #*
Address		*Email Address*

***** Complete the following only if the person authorizing the use or disclosure is not the patient:***

Name	*Relationship to Patient*	*Verification of Authority*
Representative's Address	*Phone #*	*Email Address*

By signing this form, I authorize the following:

Health information about me / the patient, described below and held by ***Stanford University, Stanford Healthcare and/or Stanford Children's Hospital,*** may be used or disclosed **from** records about my care and treatment provided by:

My protected health information may be **used by** or **disclosed to**:

□ The General Public via print, radio, television, Internet, or other similar methods; or

□ A specific entity, group, or person only (*Specify):* ____

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This health information will be used or disclosed for educational purposes, which may include but not be limited to publication in online media, books or journals, classroom instruction and/or medical training at Stanford University, other educational institutions, and/or national and international conferences.

The following protected health information may be disclosed: (*Check all that apply)*

☐ Video recorded during a procedure, surgery, or other health care encounter

☐ Photographs taken during a procedure, surgery, or other health care encounter

☐ Accounts, summaries, narratives describing a procedure, treatment or other health care encounter

☐ Other (*describe)* ____

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Description of Protected Health Information Disclosed in Video, Photos or Images:

I understand that the following identifiable information may be included in the videos, photos, poems, stories, narratives, and/or images: my facial and/or other body images and verbal descriptions about my medical condition including my prognosis as well as other related descriptions and information about the procedure or my treatment. I understand that my first name may be used for , and that not all stories will not be shared. I further understand that no other identifiable information will be made available such as my address, medical record or other identifying numbers, etc. . .

- I will not receive any compensation for my image or participation in this video/photo/image/narrative activity.
- By signing this Authorization, I am giving permission for the use or disclosure of the information described above for the purpose(s) described. I hereby release Stanford University and its agents and employees from any and all liability that may arise from the release of information as I have directed. I have the right to receive a copy of this Authorization.
- I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this Authorization.
- I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment if I refuse to sign.
- I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal health information privacy law and could be re-disclosed by the person or agency that receives it.

*______ *(Please place Initials)* I agree that this Authorization will remain in effect until I revoke it in writing.

Signature of Patient or Legal Representative: ________________________________ *Date* ___________