

**SAMPLE
AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION TO THE
MEDIA**

I authorize _____ (Hospital) to use and/or disclose health information about me, as specified below, for _____ (name of patient) to:

Reporters for local, state and national media publications, including newspapers and magazines, and to reporters for local, state and national television broadcast stations, or as otherwise specifically described: _____.

The purpose of the disclosure is: _____.

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

- Information about my specific injuries or medical condition
- Only general one-word condition
- My medical prognosis
- My age
- My city, county or state of residence
- The date and time of my expected or actual discharge from the hospital
- Information necessary to conduct an interview with me in the hospital
- Information necessary to take a photograph of me in the hospital
- Such other information as described here: _____

I understand that media representatives are not covered by federal privacy regulations and my health information may be redisclosed and no longer protected by these regulations.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization.

Unless revoked earlier, this authorization will expire when I am discharged from the hospital.

Signature of patient or patient's Personal Representative

Date

Print Patient's Name

Name of Personal Representative (if applicable)

Relationship to Patient