UCONN HEALTH

(Patient Identification)

Authorization to Use and/or Disclose Protected Health Information for Publicity Purposes

I authorize UConn Health to use and/or disclose protected health information for publicity purposes as described below.

Patient Name: _____ _____ _____
(Last) (First) (Middle Initial)

_____ _____
(Previous Name) (Email address)

_____
Address Apt/Unit City State Zip

HEALTH INFORMATION TO BE USED OR DISCLOSED:
Date(s) of Service or Date Range: _____

I authorize UConn Health to interview me and/or my health care provider(s) and/or to use and/or disclose my name, voice, image in photo, video or other medium (including medical images such as x-rays), age, sex, date(s) of service, city/state of residence, diagnosis, medications, treatment information and prognosis.

Please withhold the following information: _____

I SPECIFICALLY AUTHORIZE USE AND/OR DISCLOSURE OF THE FOLLOWING (check all that apply):

☐ Alcohol, drug, or substance abuse treatment information ☐ Behavioral health treatment records
☐ HIV/AIDS testing and/or treatment information ☐ Genetic testing information

PURPOSE OF THIS USE OR DISCLOSURE:
UConn Health publicity purposes. UConn Health may use and/or disclose your health information for marketing, advertising, and promoting UConn Health's services to the general public. In addition, UConn Health may disclose your health information to The University of Connecticut Foundation, Inc. for its use and/or disclosure related to promotional and fundraising activities on behalf of UConn Health. Your health information may be disclosed through various internal and external media, including, without limitation, television, radio, newspapers, magazines, brochures, promotional or patient education materials, exhibits, publications, email and direct mail communications, social media, and internet, including UConn Health and The University of Connecticut Foundation, Inc. websites.

- You may change your mind and cancel (revoke) this authorization at any time except to the extent that action has been taken in reliance on the authorization. **You may revoke this authorization by writing to:**

  Mail: UConn Health
  Attn: Public Information Officer
  University Communications, A-G-069
  MC2260
  263 Farmington Avenue
  Farmington, CT 06030

  Email: contact@uchc.edu
- Unless otherwise revoked, this authorization will remain valid for the purpose(s) specified.
- **The information disclosed under this authorization may be subject to further disclosure by the recipient and may no longer be protected by federal privacy regulations.**
- You have the right to refuse to sign this authorization. UConn Health may not condition your treatment, payment, enrollment or eligibility for benefits on whether or not you sign this authorization except if the sole purpose of the provision of health care is to create protected health information for disclosure to a third party.

_____ _____
Signature of Patient or Authorized Representative** Date/Time

_____
Printed name of Patient or Authorized Representative **

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Health Care Representative ☐ Conservator of the Person
☐ Executor/Administrator of Estate ☐ Other Authorized Representative: _____

**** A copy of the authorized representative's legal authority to act on behalf of the patient must be provided and retained.**

_____
Authorization Obtained by: Print Name of UConn Health Employee

Questions? Please call the Public Information Officer on call at 860-679-2000

A COPY OF THIS SIGNED AUTHORIZATION FORM MUST BE PROVIDED TO THE PATIENT OR THEIR AUTHORIZED REPRESENTATIVE.