Patient Consent to Photography/Videotaping/Interview & Authorization to Use or Disclose Protected Health Information

PATIENT NAME (PLEASE PRINT) _____ PATIENT DATE OF BIRTH _____

I AUTHORIZE: **Sentara Healthcare and its affiliated entities (together, "Sentara")**

TO DISCLOSE: Medical information about care, treatment, and diagnosis regarding the patient identified above
Limitations, if any: _____

AND CONSENT TO: Photographic/video images and interviews with/about the patient identified above to be made, used, reproduced, and/or published by Sentara Healthcare and its affiliates

TO: Sentara publications, social media and Web sites, including, but not limited to www.sentara.com, Sentara Today and Sentara Healthy Edge, as well as, all public media outlets, including, but not limited to, The Virginian-Pilot, The Daily Press, The Associated Press, WTKR TV, WVEC TV, WAVY TV, and other local, regional, national and international print, broadcast, and internet media

FOR THESE PURPOSES: Communication, promotion, education, public relations, and marketing by Sentara

- I understand and agree that these images and interviews, including my image, likeness, and/or voice, may be used in the news or by Sentara for purposes of education, promotion, public relations, and/or marketing, and that they may appear in print, on television, in radio broadcasts, or on the internet. I understand that there is a possibility that patient may be identifiable in these photographs, videos, or written/audio accounts, though patient's name will not be published unless specifically agreed to below.

  ❑ I DO ❑ I DO NOT consent to the use of patient's name in conjunction with these photographs or videos.

- I understand that the information in the patient's health record might include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, genetic testing, and diagnosis/treatment for alcohol and drug abuse. This information will be released *unless otherwise indicated below*:

  DO NOT RELEASE THIS INFORMATION: _____ (initial)

- I agree to release and hold harmless Sentara, its officers, directors, trustees, employees, and agents from any and all liability which may arise from the making of or use of these photographs, videotapes, or interviews, and I will not request payment for the use of my image or likeness. Sentara will not receive remuneration, including cash payments, for any disclosure pursuant to this authorization.
- I understand that I have the right revoke this authorization at any time by sending a written notice with a copy of this form to the Sentara HIPAA Privacy Contact Person, P.O. Box 2200, Norfolk, VA 23501. I understand that the revocation will not apply to information that has already been released in response to and reliance upon this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will not have an expiration date.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules and regulations.
- I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect patient's ability to obtain treatment, payment, or eligibility for benefits. I understand that I will receive a copy of this document.
- I certify that I am the patient, the patient's parent, or patient's legal guardian authorized to disclose this patient's protected health information.

NAME OF PATIENT/AUTHORIZING INDIVIDUAL (PLEASE PRINT) _____ **DATE** _____

SIGNATURE OF PATIENT/AUTHORIZING INDIVIDUAL _____ **RELATIONSHIP TO PATIENT/AUTHORIZING INDIVIDUAL** _____

ADDRESS (STREET, CITY, STATE AND ZIP) _____ **TELEPHONE NUMBER (DAY/EVENING)** _____

STAFF USE:

SENTARA®