Consent to Disclose Protected Health Information to Media

I authorize Ballad Health, its staff or appointed agent to use and/or disclose protected health information about _____ on this date _____.
Patient Name Date

The information may be released as specified below, to:

- Reporters for local, state and national media outlets, including newspapers, magazines, television broadcast stations, radio stations, internet and social media sites.
- The Ballad Health Marketing and Communications Department or anyone authorized by Ballad Health for marketing and promotional purposes.

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following protected health information:

___ All photography, video, audio, and/or printed testimonial taken from me on the date of this release
___ Information about my specific injuries, medical condition or prognosis
___ 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 at the hospital
___ I acknowledge, hereby consent to such, that the released information may contain psychiatric, alcohol, drug abuse, HIV testing, HIV results, or AIDS information.

I understand any and all reproductions of materials including my image, voice, condition (as outlined above) or personal testimony obtained on the date of this release remains the property of Ballad Health, and may be used for the promotion of Ballad Health and its family of services without compensation to me.

I understand that media representatives are not covered by federal privacy regulations, and my health information may be disclosed 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, payment or my eligibility for benefits.

Finally, I do understand that I may revoke this authorization at any time, provided that I do so in writing. If I revoke this authorization Ballad Health will stop the use of any and all material containing my health information covered by this authorization. I understand that Ballad Health will be unable to take back any disclosures that have already been made with my permission.

_____
PRINTED Name of Patient Signature of Patient or Representative (Parent/ Guardian) Date

_____
PRINTED Name of Patient Representative (if applicable) Relationship to Patient Date

_____
PRINTED Name of Witness Signature of Witness Date