2137

AUTHORIZATION AND CONSENT TO RECORD AUDIO AND/OR VIDEO, PHOTOGRAPH, WRITE, AND PUBLISH

I, (Guardian's Name) _____ (print full legal name), the undersigned, do hereby authorize Loma Linda University Health (LLUH), its affiliates, and its designated representatives to record identifiable/non-identifiable audio and/or video, to take identifiable/non-identifiable photographs, write, publish, and distribute identifiable/non-identifiable information about me and/or the dependent named below for whom I serve as legal guardian, in such manner as LLUH, its affiliates, and its representatives deem appropriate.

I further authorize LLUH, its affiliates, and its designated representatives to publish any identifiable/non-identifiable photos or other assets that I provide for their use _____ (initial ONLY if providing media assets).

I agree that LLUH, its affiliates, and its designated representatives may use and permit others to use all media forms known now or created in the future and/or written information as deemed appropriate for such purposes including, but not limited to, dissemination to LLUH and its affiliates' staff, physicians, health professionals, students, and members of the public for educational (e.g. teaching/conferences), treatment, research, scientific, public relations, marketing, news media, and/or charitable purposes. I agree that such dissemination may be accomplished in any manner and publication medium deemed appropriate by LLUH, its affiliates, and its designated representatives, and that such dissemination is subject only to the following limitations: NO LIMITATIONS

I understand authorizing the use/disclosure of the information identified above is voluntary.

I need not sign this form to ensure health care treatment. I understand that I have the right to revoke this authorization at any time by submitting my request in writing to the department indicted on the bottom of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to any insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, or expired, this authorization will remain valid.

I understand that I may inspect or obtain a copy of the information to be used/disclosed, as provided in 45CFR164.524. I understand that any use/disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about use/disclosure of my health information in general, I can contact the Health Information Management Department at (909) 651-4191. For questions about the use/disclosure of my health information for publication purposes, I may contact the Advancement Department at (909) 558-4544.

I agree to assist LLUH, its affiliates, and its designated representatives in pursuing scientific, treatment, educational, public relations, marketing, news, and/or charitable goals, and I do hereby waive my rights and/or the rights of my dependents/successors to compensation for such uses. I, the undersigned, and my dependents/successors will hold LLUH, its affiliates, and its designated representatives harmless from and against any claim for injury and/or compensation resulting from the activities authorized by this agreement.

I understand this authorization expires (insert date): 01/01/2120 or at the end of day 365 from today's date if an expiration date is not provided.

Upon expiration of this authorization, LLUH, its affiliates, and its designated representatives will not permit further release of any photographs, audio recordings, videos or any other information, but will not be able to call back any photographs, audio recordings, videos or any other information already released.

Signature:_____ Date/Time: _____
(Patient/Non-patient/Legal Representative)

Print Name:_____ DOB/Last four SSN:_____
(For patients only)

Address *(optional)*:_____

Phone:_____ Email:_____

If signing as legal guardian for another individual, please print your dependent's name and your relationship to him/her:

Dependent's Name:_____ Relationship:_____

Witness:_____ Date/Time:_____

Patient/Guardian Authorization to Contact Health Care Providers and/or Publish Protected Health Information

I,_____ (print full legal name), do hereby authorize LLUH, its affiliates, and its designated representatives to speak with health care providers about my care, or that of the dependent named above for whom I serve as legal guardian, regarding Protected Health Information deemed pertinent and appropriate for the purposes and limitations listed on this authorization form. I also authorize the publishing of that Protected Health Information according to the terms of this authorization.

Signature_____ Date_____

LLUH Health Information Management (HIM) **101 E. Redlands Blvd., Suite #1200** **San Bernardino, CA 92408** **Ph: (909) 651-4191**	LLUH Advancement **P.O. Box 2000** **Loma Linda, CA 92354** **Ph: (909) 558-4544**

FREQUENTLY ASKED QUESTIONS

Who is permitted to disclose my medical information?
Loma Linda University Health, its affiliates, and its designated representatives

How will my information be used?
Your information may be used for the following purposes, including but not limited to, dissemination to LLUH and its affiliates' staff, physicians, health professionals, students, and members of the public for educational (e.g. teaching/conferences), treatment, research, scientific, public relations, marketing, news media, and/or charitable purposes.

May I request to inspect or obtain a copy of the information to be used/disclosed?
Yes.

What happens after my photos and information go public?
Please note that once information is published, the information resides in a public domain that may not be protected by federal confidentiality rules. Other outlets may use and/or redistribute the published information. For example, a published story could be picked up by news networks and/or magazines. LLUH, its affiliates, and its designated representatives cannot guarantee that other organizations will not use your published information.

I'm not sure I want to make my information public. Do I have to sign this form?
No - signing this form is completely voluntary and will not impact services (e.g. treatment, fees or insurance benefits) provided to you at LLUH or at one of its affiliated entities.

May I withdraw my consent?
Yes. You may cancel/revoke your authorization at any time. You will need to submit a written revocation notice to the applicable department - HIM or Advancement. Please note that we will not be able to retrieve any information already used/disclosed under this authorization prior to our receipt of your written revocation notice.

LLUH Health Information Management (HIM) **101 E. Redlands Blvd., Suite #1200** **San Bernardino, CA 92408** **Ph: (909) 651-4191**	LLUH Advancement **P.O. Box 2000** **Loma Linda, CA 92354** **Ph: (909) 558-4544**

When does my consent expire?
This consent expires on the date indicated on the authorization form. If a specific date has not been provided, the consent will automatically expire at the end of day 365 from the date the authorization was signed.