HONORHEALTH®

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION TO PUBLISH OR PHOTOGRAPH RELEASE

☐ **PATIENT** ☐ **EMPLOYEE**	Name (print) Address City State Zip	Purpose:
HONORHEALTH HOSPITAL OR FACILITY	(Insert department and phone number, hospital or facility name, address, city, state, zip)	

The Undersigned hereby authorizes HonorHealth ("HONORHEALTH"), or the above hospital, or anyone authorized by HONORHEALTH to:

1. Act as an intermediary, making it possible for (name/agency) to interview, quote, and/or photograph still or film for purposes of publication in newspapers, magazines, or other printed media or for broadcast by means of radio or television transmission, social media, or for use on the intranet or internet or any other medium deemed appropriate by HONORHEALTH,
2. Use the above person's name in connection with any electronic or print publications (including but not limited to newspapers, television and/or radio broadcasts, books, brochures, magazines, motion pictures, and web and/or social media sites) for publicity, scientific or educational purposes in such manner and at such times and in such places as HONORHEALTH or the person authorized by HONORHEALTH shall determine.
3. Use any quotation and comment made verbally or tape recorded by the above-named person and/or his or her designated representative concerning the above-named patient and such patient's medical case.
4. Take and reproduce in photographic or digital form pictures, slides and audio/video recordings of the above- named person in connection with the diagnosis, care and treatment (including surgical procedures) or departmental functions at the above-named facility. HONORHEALTH shall own unrestricted rights to all materials produced.

   Use such pictures, slides and audio/video recordings in any electronic or print publication (including but not limited to newspapers, television and/or radio broadcasts, books, brochures, magazines, motion pictures, and web and/or social media sites) for publicity, scientific or educational purposes in such manner and at such times and in such places as HONORHEALTH or the person authorized by HONORHEALTH shall determine.

I understand that I may refuse to sign this authorization form and that HONORHEALTH will not change or deny treatment based on my signing or not signing this authorization.

I understand that if information is disclosed to a third person, including media, that the information can no longer be protected by state and federal regulations, and may be re-disclosed by the person or organization that receives the information

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken.

Unless otherwise revoked, I understand that this authorization has no expiration date. To revoke this authorization, please submit your request in writing to: HonorHealth Health Information Management Department, 7400 E. Osborn Road Scottsdale, AZ 85251.

I release HONORHEALTH, its affiliates and subsidiaries, employees and agents, medical staff members and business associates from any legal responsibility or liability for disclosure of the above images and information to the extent indicated and authorized herein.

Signature of Patient, Employee or Model

Date

Signature of Legal Representative or Parent (If under 18 years)

Relationship to Patient/Model or description of Authority to Act on behalf of Patient