AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR PUBLICATION PURPOSES

I, _____ and if applicable _____,
(Patient's Name) (Parent/Guardian's Name)
authorize Loyola University Health System, its parent, subsidiaries and affiliates including Loyola University Medical Center, Gottlieb Memorial Hospital, Gottlieb Community Health Services Corporation, MacNeal Hospital (collectively, "Loyola Medicine") and its or their respective directors, officers, agents and employees, to use, disclose and publish my likeness, voice, biographical information, health information and/or other information in any medium for educational, academic, and other purposes as described below:

PATIENT NAME _____ DATE OF BIRTH _____

PARENT/GUARDIAN NAME (if applicable) _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____ PHONE _____

1. Loyola Medicine (Department, if applicable: _____) staff are allowed to use and disclose my information.
2. Person or types of persons who will receive the information:
   - ☐ Healthcare Professionals
   - ☐ Publication distribution
   - ☐ Other: _____
3. I give permission for the following information to be used/disclosed:
   - ☐ Photo(s) Date(s) taken: _____
   - ☐ Video footage Date(s) filmed: _____
   - ☐ Audio Date(s) recorded: _____
   - ☐ Specific health information Describe: _____
   - ☐ Other Describe: _____
4. I authorize the information to be used or disclosed for the following purposes:
   - ☐ Publications (professional journals)
   - ☐ Presentations (professional conferences and meetings)
   - ☐ Other: _____
5. I understand that the information included in the publication or presentation may make it possible for someone to identify the patient.

6. I understand that this authorization is given without promise of compensation or requirement of any future services. I release to Loyola Medicine any right, title and/or interest of any kind that I may have in the information or images produced.

7. MY HIGHLY CONFIDENTIAL INFORMATION: By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization.

   ☐ Psychiatric/mental health, mental retardation or developmental disabilities information (Parent/guardian co-signature required for patients 12-17 years old)

   ☐ HIV and AIDS testing, diagnosis or treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)

   ☐ Communicable disease, including sexually transmitted diseases diagnoses/lab results/treatment

   ☐ Alcohol/drug abuse or addiction diagnosis/treatment

   ☐ Child abuse and neglect

   ☐ Domestic abuse by an adult

   ☐ Sexual assault

   ☐ Genetic testing

   You must acknowledge you are checking these categories by furnishing your written signature here.
   Signature: _____

IF I AM A LOYOLA MEDICINE PATIENT:

- I understand that I may refuse to sign this authorization and that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on my signing or refusing to sign this authorization.
- I understand that I may inspect and/or receive a copy of my photo, video, audio tape and/or health/biographical information that was used or disclosed under this authorization, or the publication/presentation.
- I understand that if the person or entity that receives my information is not a healthcare provider or health plan covered by federal privacy regulations, the protected health information described above may be re-disclosed and no longer protected under federal or state privacy laws.
- I understand that I may revoke this authorization in writing at any time. I understand that revocation of this authorization will not affect use or disclosure of photos and/or health/biographical information that was previously provided with my consent. Although I have the right to revoke this authorization, such revocation will not apply to any uses and disclosures of my protected health information that are described in the Loyola Medicine Notice of Privacy Practices or otherwise allowable under any federal or state laws. Revocation requests should be directed to the address below.
- I understand that this authorization will remain in effect until revoked by me or until it expires in three (3) years from the date of my signature below.

SIGNATURES

_____

Signature of Patient, Parent/Guardian or Legal Representative Date

_____

Name of Parent/Guardian or Legal Representative (if applicable) Relationship to Patient

If signed with an "X," two witnesses are required to sign.

_____ _____

Witness 1 Witness 2

For questions, contact:
Loyola Medicine Office of Integrity
2160 S. 1st Avenue,
Maywood IL 60153

FOR DEPARTMENT USE – Information About Loyola Medicine Employee Obtaining Authorization

Name:_____Title:_____

Signature:_____

Maintain original copy of this form in the department and provide a copy of this form to patient/individual if requested.