SR0735
Rev. 8/23

DukeHealth

Name_____

Contact Info_____

Physician_____

Keywords_____

DUKE HEALTH ENTERPRISE AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION FOR DUKE COMMUNICATIONS, MEDIA RELATIONS AND EDUCATIONAL PURPOSES

I_____, the ☐patient or ☐personal representative of the patient (check one), authorize Duke University, Duke University Health System, Duke Health Integrated Practice (DHIP), and other members of the Duke Health Enterprise identified in its Notice of Privacy Practices (collectively "Duke"), as well as any duly authorized affiliates, subsidiaries and physicians to use, disclose, store and archive the following designated materials and health information of (patient name)_____ to the public for the activities and purposes described below:

Specific materials and health information to be used, disclosed, stored or archived for the public activities and purposes identified below.

***Information selected below may include facility name and treatment location(s), unless otherwise specifically excluded under 'Exceptions or special instructions'.**

Check all that apply

☐ Photographs, video, audio

☐ Demographic information; such as, name, age, city/county and state of residence

☐ Diagnosis and treatment information, including treatment date(s), and provider name(s)

☐ De-identified medical images, scans, x-rays (may still include identifying characteristics and/or procedures)

☐ Exceptions or special instructions:_____

I agree to participate, or permit my providers or other staff to participate, in an interview; to have photographs and/or audio and video recordings taken; and that these materials and any other health information identified above may be used, disclosed, stored or archived for the public activities and purposes marked below:

☐ For all purposes listed below

☐ News media (including television, newspapers, radio, podcasts, websites, and all associated social media channels), and Duke social media platforms and websites

☐ Duke consumer marketing, development, and community relations, including associated Duke websites, social media platforms, and other publications or materials

☐ Duke physician marketing, including print and electronic materials

☐ Duke training, education, or medical illustration

Commercial instructional or health educational materials by the following Duke approved third-party:

_____

Notes or special instructions: _____

I understand that once the materials and health information identified above are publicly used or disclosed as provided in this authorization, Duke may not retain control over the further use or disclosure of these materials and health information by any third party, including other people, entities and media, and also that these materials and information may no longer be protected by federal or state privacy law. In particular, I understand that, after publication and/or distribution, these materials and health information may be picked up, reprinted and/or rebroadcast and disclosed by other people, entities and media who are not connected to Duke.

Duke cannot limit the amount of time the media may use footage for future print or online publications or broadcast, rarely has final control over the use or (re)distribution of such materials, and cannot guarantee that other entities will not capture and display on their own websites or other communications media information that I have authorized to be disclosed by Duke above, despite Duke's copyright.

I understand that I will receive no compensation from Duke for this authorization or for anything described herein. I also understand that my health care treatment or payment for health care services at Duke is not conditioned upon my giving this authorization. I have read this form and fully understand the contents. I agree to be bound by this authorization. I acknowledge and represent that I am the patient whose health information is the subject of this authorization and that I am 18 years of age or older or that I am the personal representative of the patient whose health information is the subject of this authorization.

This authorization for Duke's purposes expires at the termination of the last of the activities described above in which I have agreed to participate. Specifically, the termination date occurs at the conclusion of the last activity that includes the above described materials and my health information.

I may revoke this authorization at any time, which I must provide in writing and send to **DUHS Health Information Management, DUMC Box 3016, Durham, NC 27710; or ROI-requestor3@dm.duke.edu**. I understand this revocation will not affect any uses or disclosures prior to such revocation. I understand I may review or obtain a copy of the health information subject to this authorization by making a request in writing and sending it to the address above.

_____ _____ _____

SIGNATURE of Patient/ Personal Representative DATE TIME

_____ _____

PRINTED NAME RELATIONSHIP to PATIENT

A signed copy of this form will be provided to patient or personal representative at the time of execution.