Patient Authorization to Disclose Protected Health Information

I authorize UofL Health, Inc. and its affiliates, including without limitation, University of Louisville, University of Louisville Physicians, Inc., University Medical Center, Inc., d/b/a University of Louisville Hospital and Brown Cancer Center, UofL Health – Louisville, Inc., and UofL Health – Shelbyville, Inc., and their respective executives, directors, employees, contractors, agents, and representatives (collectively, "UofL Health"), to use and/or disclose my Protected Health Information as specified in this authorization.

I authorize UofL Health to use and disclose the Protected Health Information specified below, including my Protected Health Information contained in any photograph(s), videotape, and/or interview recording, for the following purposes:

- Use in internal and external advertising, marketing, or collateral materials;
- Use in news releases or stories, including television, newspaper, or radio broadcasts; and
- Use in public relations materials.

I further authorize UofL Health to disclose my Protected Health Information to external news or media entities for use and disclosure in connection with news releases or stories, and other promotional or public relations materials being created or managed by that entity.

I understand that the Protected Health Information I am authorizing UofL Health to use and/or disclose may include my name and contact information, demographic information, health information, treatment information, and information about my health care services, except as specifically described as follows (please describe if applicable):__.

I provide my authorization knowing that:

- I understand that Protected Health Information that is used or disclosed pursuant to this authorization, including Protected Health Information contained in any photographs, videotapes, or interviews, may be subject to redisclosure by the recipient(s) and may no longer be protected by HIPAA or other state or federal laws.
- **I understand that signing this authorization is voluntary. I have the right to refuse to sign this authorization. My treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on my provision of this authorization.**
- I understand that I can revoke or cancel this authorization at any time by sending written notice to the UofL Health, Inc., Attn: VP of Compliance and Audit Services, 300 E. Market Street, Suite 400, Louisville, KY 40202.
- If I revoke or cancel this authorization, I understand that the revocation will not apply to Protected Health Information that has already been used or disclosed in reliance on my authorization or any future use or disclosure of such information.
- My signature below serves as acknowledgement that I have received a copy of this authorization for my records.

Unless I revoke this authorization, it will expire 5 years from the date below, or on an earlier date if specified here: _____

Patient Name (Print)	Patient Signature	Date
Legal Representative (Print name, if applicable)	Legal Representative Signature	Date
Legal Representatives Relationship to Patient (if applicable)		

RELEASE

I authorize the photographing, recording and unlimited use of my likeness (including my name, voice and/or image) for commercial, promotional or other use, in any medium, by UofL Health, Inc. and its affiliates, including without limitation, University of Louisville, University of Louisville Physicians, Inc., University Medical Center, Inc., d/b/a University of Louisville Hospital and Brown Cancer Center, UofL Health – Louisville, Inc., and UofL Health – Shelbyville, Inc., and their photographers and videographers (collectively, "UofL Health").

I waive all rights of attribution, inspection, or approval for any use of my likeness. I agree to hold UofL Health and its executives, directors, employees, contractors, agents, and representatives harmless for any liability, legal and/or financial, incurred as a result of said use.

I waive any right to royalties or other compensation arising from or related to the use of my likeness. All right, title, and interest to any photographs, recordings, and any other materials using my likeness shall be the sole property of UofL Health, Inc. I shall have no interest in any such materials nor shall I have any right to use the name or trademarks of UofL Health, without their respective written permission.

I have read this release before signing below, I understand the contents, and I agree that I have the right to execute this Release and to grant the rights described above.

Name (Print)	Signature	Date
Legal Representative Name (Print) (if applicable)	Signature	Date
Legal Representatives Relationship to Signer		