



RUTGERS, THE STATE UNIVERSITY OF NEW JERSEY
HIPAA AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION
AND CONSENT/USE OF PHOTOGRAPHS AND AUDIO/VIDEO IMAGES

Rutgers, The State University of New Jersey, ("Rutgers") is always pleased when patients are willing to communicate the stories, experiences, and information about their treatment received at Rutgers. Sharing your story can help others who are interested in knowing more about the patient services provided by Rutgers health care providers and can help Rutgers promote its mission of service.

Rutgers respects the privacy of our patients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities. Rutgers seeks your permission to use your medical information and your consent to allow us to take and use audio/video/photographic material of you in Rutgers' internal and external communications, including medical and general interest publications and medical and patient education information, and distribute such materials online, in print, and in news media (such as TV, radio, newspapers, and magazines).

To ensure that Rutgers is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to fill out and sign this form. Rutgers will keep a copy of your written permission on file.

- I do give my permission for Rutgers to use my or my child's name and share details of my or his/her treatment and experience as a patient in communications produced by or on behalf of Rutgers, and consent to take and make use of my and/or my child's audio/ video/photographic images in publications produced by or on behalf of Rutgers. This permission extends both to electronic versions on the Rutgers websites and other internet/electronic applications as well as to printed, filmed, and taped versions.
I do give my permission for Rutgers to release my or my child's name and details of his/her medical care to the news and electronic media including, but not limited to, internet/online publications, TV, radio, newspapers and/or magazines, and allow the news media to make images (digital, video, or otherwise) of me or my child for purposes of illustrating my treatment and experience as a patient of Rutgers.
I specifically authorize the release of information pertaining to alcohol, drug, and/or substance abuse, diagnosis, or treatment.
I specifically authorize the release of information pertaining to mental health diagnosis or treatment.
I specifically authorize the release of information pertaining to HIV/AIDS test results.

I am not required to sign this authorization. Rutgers does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I can request a copy of this authorization be mailed to me. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of any information and audio/video/photographic material.

If I decide to sign this form, I have the right to request that audio/video recording, filming, or photographing cease at any time.

I am aware that my protected health information will exist forever in either a recorded, printed, and/or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used. I understand that information about me or my child used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law.

I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to the Rutgers Privacy Officer at Office of Enterprise Risk Management, Ethics and Compliance, 65 Bergen Street, Suite 1346, Newark, NJ 07107. I understand that Rutgers, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Rutgers' control that have not been previously published. If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it.

Patient Name: (first) (m. initial) (last)
Signature: Date:
Address: (street address) (city) (state) (zip code)
Phone: (area code) (home or mobile phone number)

For personal representatives, please provide the following:

I (insert your name) represent that I am the health care agent/guardian/surrogate/parent of the patient above. (circle one of the above)

Personal Representative Signature:

Address: Phone:

*If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient.