Mount Sinai

Authorization for Release of Protected Health Information (PHI) for Media Relations

LAST NAME:____ **FIRST NAME:** ____________________________

ADDRESS: ____

TELEPHONE: __________________________

1. I authorize the following entity or entities of Mount Sinai Health System and/or the following physician(s):

___ The Mount Sinai Hospital ___ Mount Sinai Roosevelt ___ Mount Sinai Beth Israel
___ Mount Sinai Queens ___ Mount Sinai St. Luke's ___ Mount Sinai Brooklyn
___ New York Eye and Ear Infirmary of Mount Sinai ___ Icahn School of Medicine at Mount Sinai

___ Other Mount Sinai entity (please write in name) ____

Physician name(s): ____

… to disclose my personal and/or medical history and/or treatment related to the following condition(s) or procedure(s):

____

… to the general public via the following news media:

____

… for purposes of publicizing, promoting, marketing and advertising their activities, programs and services. This use might include, but is not limited to, media in the form of one or more of the following: photograph, video, movie or audio recording. I affirm that I have previously provided verbal authorization for disclosure of this PHI to Mount Sinai Communications personnel or agents to facilitate arrangements.

2. I understand that in the future media that I am in and the accompanying narrative may be placed in the Mount Sinai Archives, where it may be used in historical displays or publications. My name would not be used in connection with any future use.

3. I understand that this authorization is valid for the duration of Mount Sinai's institutional archives and that I may revoke it at any time, except to the extent that Mount Sinai has already taken action based on it. (To revoke this authorization, write to: Marketing, Communications, and Public Affairs, The Mount Sinai Medical Center, Box 1107, One Gustave L. Levy Place, New York, NY 10029)

4. By signing this form, I authorize the use or disclosure of the Protected Health Information as described above. This information may be re-disclosed if the recipient(s) described on this form is/are not required to protect the privacy of the information, and such information is no longer protected by federal health privacy regulations.

- Please initial if you are authorizing release of HIV-related information, you should be aware that the recipient(s) is/are prohibited from re-disclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. ___________

- If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at 212-870-8624 or New York City Commission of Human Rights at 212-566-5493. These agencies are responsible for protecting your rights.

I understand that I am not required to sign this authorization and that my health care, payment for health care and health care benefits will not be affected if I do not sign this form.

SIGNATURE:____ **Date:** ________________
(Patient or Personal Representative)

Personal Representative: [Print Name] ____

Authority: ____ **Telephone:** __________________________

Address: ____

Witness: [Print Name] ____________________________________ **Witness's Signature:** ______________________________

MR-207 (Rev. 10/2015)