TEXAS HEART® INSTITUTE
at St. Luke's Episcopal Hospital

Authorization to Disclose Information

I,_____, acting on behalf of myself or as the legally authorized representative of _____ , hereby authorize public disclosure of information as indicated:

Media Interviews

_____ I desire to participate in an interview(s), and I may disclose my healthcare information as I choose during the interview(s). I agree to hold Texas Heart Institute at St. Luke's Episcopal Hospital harmless from any and all liability arising from this interview(s) and any news articles(s) printed or broadcast as a result of this interview(s). I also understand that the information that I disclose to the media in the interview may no longer be protected under state and federal privacy regulations and may be subject to re-disclosure by the media.

Media, Recording, Filming, Marketing Collateral or Advertising (includes photographs, video, brochures, electronic or print media)

_____ I authorize _____ to record or film me as may be desired to illustrate a procedure, treatment, condition or operation, and to permit such recording or film to be published and republished in professional journals or medical books, to be used for news stories/articles, or to be used for any other purpose(s) as deemed appropriate. I understand that the information that I release to the media during the recording or filming of me may no longer be protected under the terms of the state and federal privacy regulations and may be subject to re-disclosure by the media.

Designated Media or Marketing Representatives

Intended use of recording or film _____

_____

Name/organization of photographer/videographer_____

_____

_____In agreeing to the recording or filming, I authorize the release of my identity.

_____In agreeing to the recording or filming, I do not authorize the release of my identity.

I, as a patient or the legally authorized representative of the patient, understand that at any time during recording or filming I have the right to request cessation of recording or filming and to have such request honored.

I, as a patient or the legally authorized representative of the patient, understand that I have the right to rescind my authorization to participate in interviews, recording or filming and to have such interview, recording or filming cease. I may also rescind, in writing, this authorization except to the extent that actions have been taken in reliance on my authorization.

I agree to hold Texas Heart Institute at St. Luke's Episcopal Hospital harmless from any and all liability arising from activities related to the recording or filming.

I, _____hereby certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

_____ _____

Date Signature of Patient

_____ _____

Signature of Patient's Legally Authorized Representative Witness

_____

Relationship to Patient

ST. LUKE'S Episcopal Health System

Authorization to Disclose Information

I,_____, acting on behalf of myself or as the legally authorized representative

of_____, hereby authorize public disclosure of information as indicated:
Patient's Name

Media Interviews

_____"I consent to participate in an interview(s), and I authorize disclosure of my protected healthcare information as I choose during the interview(s). I agree to hold St. Luke's Episcopal Health System harmless from any and all liability arising from this interview(s) and any news articles(s) printed or broadcast as a result of this interview(s). I also understand that the protected health information that I disclose to the media in the interview may no longer be protected under state and federal privacy regulations and may be subject to re-disclosure by the media."

Media, Recording, Filming, Marketing Collateral or Advertising (includes photographs, video, brochures, electronic or print media)

_____ "I authorize _____, to record, film or photograph me as may be
Designated Media or Marketing Representatives

desired to illustrate a procedure, treatment, condition or operation, and to permit such recording, filming or photographing to be published and republished in professional journals or medical books, and/or to be used for news stories/articles/marketing collateral, advertising, and/or to be used for any other purposes (s) as deemed appropriate. I consent and authorize disclosure of my protected healthcare information to be released to the media or public during the recording, filming or photographing of me. I understand that I may no longer be protected under the terms of the state and federal privacy regulations and may be subject to re-disclosure by the media."

Intended use of recording, filming or photographing (specify details):

Name/organization of photographer/videographer:

_____In agreeing to the recording, filming or photographing, I authorize the release of my identity.

_____In agreeing to the recording, filming or photographing, I do not authorize the release of my identity.

I, as a patient or the legally authorized representative of the patient, understand that at any time during recording, filming or photographing I have the right to request cessation of recording, filming, photographing and to have such request honored.

I, as a patient or the legally authorized representative of the patient, understand that I have the right to rescind my authorization to participate in interviews, recording, filming or photographing and to have such interview, recording, filming or photographing cease. I may also rescind, in writing, this authorization except to the extent that actions have been taken in reliance on my authorization.

I agree to hold St. Luke's Episcopal Health System harmless from any and all liability arising from activities related to the recording or filming

I,_____ hereby certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

Date: _____

Signature of Patient: _____

or

Signature of Patient Legally Authorized Representative: _____

Relationship to the Patient: _____

Witness (not St. Luke's): _____