Saint Barnabas Medical Center
Barnabas Health

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PATIENT NAME (Print): _____

D.O.B.:_____ Phone Number _____

Address: _____

HIPAA Authorization for Disclosure of Medical Information:
I hereby give permission to the Marketing and Public Relations Department of Saint Barnabas Medical Center (SBMC) of Livingston, NJ, its agents, contractors, and employees (collectively, "SBMC Marketing and PR"), and to my physician, Dr. _____, to use and to disclose my health information to the media (including but not limited to TV, magazine, internet, newspaper), and in and to other promotional venues in connection with SBMC's marketing and public relations purposes.

I also authorize and consent to the taking, use and disclosure of photographs and moving pictures of me, to be included in articles, video or other media about me together with my medical information described below, in connection with promotional activities, teaching, and publicity by SBMC.

The information about me to be used and disclosed relates to **anything within my personal medical history that I or the physician noted above discusses with SBMC Marketing and PR**. I understand that the information to be used and disclosed about me includes **my identity, diagnosis and treatment.** SBMC Marketing and PR will **not** be accessing my medical records.

If **I choose to provide** SBMC Marketing and PR with information on the following, then the disclosure may include information about my use of ALCOHOL or DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED and INFECTIOUS DISEASES, and/or my AIDS and HIV status, as applicable.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to The SBMC Marketing and Public Relations Department, with a copy to the SBMC Health Information Management Department, both at 94 Old Short Hills Road, Livingston, NJ 07039. I understand that SBMC cannot take back any releases of my health information that SBMC already made before I revoked. Therefore, any revocation will not apply to the extent that SBMC has already taken action in reliance on this authorization. This authorization will automatically **expire 5 years from the date below my signature**, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition:_____.

I understand that authorizing this disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure, and once my information has been released to the media, my medical information will not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the SBMC Health Information Management Department at (973) 322-5835.

Liability Release for Taking and Using Photos and Video:
I hereby release Saint Barnabas Medical Center, its medical staff, agents, contractors and employees from all liability related to the making and use of my image in photographs and moving pictures, for use in media and for any public relations or marketing purposes. I am NOT releasing SBMC from its obligation to maintain the confidentiality of medical information. I understand that SBMC Marketing and PR may only use and disclose my information as described above.

Signature for both HIPAA Authorization and Liability Release:

_____

Date:_____