



Authorization and Release to Use and Disclose Information for Media or Communications

Child name: (Please print legibly) _____ Date of Birth: _____

Address: _____

Phone number: _____ Home: Cell: E-mail: _____

1. Authorization

- a. This Authorization and Release allows Intermountain Healthcare to release the following information about you to the public: your name, your image (photograph, video, film, etc.), your story and statements, relevant - but limited - medical and billing information (e.g. your diagnosis, treatment method, procedures or technology used, charity care if applicable).
- b. If you don't want Intermountain to disclose certain information, please put a check next to the information that you **DON'T** want disclosed.
 - Full name
 - Image (photographs, video, film, etc.)
 - My story and statements
 - Medical information (diagnosis, procedures, treatment information, etc.)
 - Other (if applicable) _____

2. Understanding

I understand the following.

- a. I can refuse to sign this Authorization and Release.
- b. I can cancel this Authorization and Release at any time and for any reason by writing Intermountain's Communications Department. If I do that, my information cannot be disclosed after I cancel. Otherwise, this authorization and release will continue in effect as long as Intermountain Healthcare is actively providing healthcare services.
- c. Refusing or changing my mind about this Authorization and Release will not negatively affect me or my family in terms of healthcare treatment, payment for that healthcare, or patient benefits.
- d. Federal privacy rules govern Intermountain Healthcare's use of this information. (For more information about Intermountain Healthcare's use of health information and your health-information Privacy Rights, ask for a copy of Intermountain Healthcare's Notice of Privacy Practices.)
- e. I understand that others will see the information that I authorize to share publicly. Those who see this information may not be governed by the same privacy rules that apply to Intermountain Healthcare.
- f. I understand what information may be released under this Authorization and Release.

3. Signature

By signing below, I release my information to, and authorize, Intermountain Healthcare to disclose that information in publications, for example in electronic, audio, and printed form in news media; in publications, advertising brochures; and fundraising pamphlets, social media and other communications. My questions about this Authorization and Release have been answered to my satisfaction.

Signature of patient or subject: _____

Legal Representative _____ Date: _____

If signed by a Legal Representative, state the relationship to the subject: _____

Signature and name of Witness (optional): _____