Authorization to Information to the Media, for Marketing/Advertising, and Community Outreach/In-reach Activities Disclose Health

FDNY covered component, its facilities, and its business associates understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

Name of patient whose information will be used or disclosed:			
Name and address of person signing this form:	Name:		
	Address:		
	City:	State:	Zip:
	Phone:		
Facility/Provider authorized to disclose the information:	Name(s):		
Who will be given the information?:	Name:		
	Address:		
	City:	State:	Zip:
	Phone:	Fax	
I authorize the release of information for the following purposes:	■Media (including print, radio, television, and Internet) ☐Marketing ☐ Advertising	☐ Training ☐ Community outreach/in-reach activities ☐Other (please specific) _____ _____	
I authorize the release of information in the following (manner(s):	☐ Interview ☐ Photograph ☐ Film/videotape	☐ Audio recording ☐ Other (please specific) _____ _____	
I authorize the disclosure of the following type(s) of information:	☐ Genetic Information ☐ Alcohol and/or Substance Abuse information	☐ HIV/AIDS related information ☐ Mental Health Information	
For marketing disclosures only:	☐I understand than FDNY covered component will receive direct remuneration for the marketing of products or services related to this disclosure.		

A copy of this authorization must be provided to the patient/personal representative.

Contact Bureau of Legal Affairs regarding law-related photo/recording/video requests.

I authorize FDNY to disclose my personal and/or medical history and/or treatment information, as indicated on this form.

I understand that I do not have to sign this authorization. My refusal to sign this document will not impact my treatment, payment, enrollment in a health plan or eligibility for benefits in any way. However, if I do not sign this document, I understand that I will not participate in the activities indicated on this form.

I understand that FDNY and other organizations and individuals, such as physicians, hospitals, and health plans are required by law to keep my protected health information confidential. If I have authorized the disclosure of my protected health information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws.

I understand that I may change my mind and revoke this authorization so long as no action has been taken on my authorization (for example, I cannot change my mind *after* the interview has already aired on television). The revocation must be in writing, signed by me, and delivered to the Director of the Press Office.

If I am authorizing the use of HIV-related information, the recipient is prohibited from re-disclosing such information that I have authorized on this form unless permitted by federal or state law. I understand that I have a right to request a list of people who may receive or use my HIV -related information without authorization. If I experience discrimination because of the release or disclosure of my HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting my rights.

If the information I agree to disclose relates to Alcohol or Drug Abuse, Genetic Testing, Mental Health and/or confidential HIV/AIDS-related information, I specifically authorize the information to the person(s)/entity indicated on this form. I understand that additional form (s) may be required for the release of these categories of information.

I understand that this authorization will expire when the activity/activities above are completed, or _____ (date), whichever is earlier.

Signature of Patent or Personal Representative	Date
Print Name of Patent or Personal Representative	Description of Personal Representative's Authority to Act