

AUTHORIZATION FOR PATIENT PHOTOGRAPH, VIDEOTAPING, OR OTHER VISUAL/AUDIO IMAGE

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|------------------------------------|-------------------------|
| Patient's Name (Last, First, M.I.) | "C" No. |
| | |
| Sex | Date of Birth |
| | |
| Facility Name | Unit/Ward/Residence No. |

This form must be executed whenever a patient photograph, videotape, or other visual/audio images is sought to be recorded and released for a purpose other than treatment, payment, or health care operations. If this form is to be signed by a patient, the witness must be a physician who has conducted an interview and examination of the patient and determined that the patient is capable of executing the authorization and is doing so willingly as his/her own voluntary act.

I, the undersigned, hereby consent and authorize the Office of Mental Health and (Organization) _____, to take, use, and disseminate photographs or (other) _____ of (Name of Patient) _____, and to release appropriate identifying information.

I understand that in the course of making such photographs, videotapes, or other images, I may be disclosing individually identifiable health information about myself to the Organization. I also understand that such photographs, videotapes, or other images will be used to promote public understanding and support of programs for the mentally disabled.

I also understand that:

1. Only this information may be used and/or disclosed pursuant to this authorization.
2. This information is confidential and protected from disclosure.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
4. I have the right to revoke this authorization at any time. My revocation must be in writing on the form provided to me by (insert name of facility/program) _____. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. _____ may receive compensation for its use/disclosure of my information (I understand this does not apply if I am requesting the use/disclosure).
7. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524).

I further understand that this authorization will expire:

- When acted upon;
- 90 Days from this Date;
- Other _____

I certify that I have received a copy of the authorization.

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|---|---|
| Signature of Patient or Personal Representative | Date |
| Patient's Name (Printed) | |
| Personal Representative's Name (Printed) | Nature of Personal Representative's Relationship to Patient |
| Signature of Witness | Date |
| Witness' Name (Printed) | |