Carolinas HealthCare System

Patient Information: I give permission to release the photographs, videos, and health information of: **(One Patient Per Form)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN:_____

City, State, Zip: _____ Telephone: ( ) _____

Account #: _____ Email address: _____

Release Information From:

Carolinas HealthCare System
(List applicable Facility(s) and/or Practice(s)

_____

_____
(Phone number) (Fax number)

Release Information To:

Local, regional, or national media outlets, including social media outlets; the public; CHS marketing recipients; CHS Foundation; other third parties designated by CHS
(Name of facility, person, company) (Relationship)

_____
(Street Address or PO Box, City, State, Zip Code)

_____
(Phone number) (Fax number)

PURPOSE OF RELEASE: Unless otherwise noted this release is for any or all of the following purposes: Publication in newspaper(s), magazine(s) or other publications, Broadcast by radio or television, Carolinas HealthCare System internet sites and marketing and public relations materials/publications, Facebook, YouTube, other social media, Patient or Public education materials and brochures

_____

Form of Patient Information:

All forms may be used unless otherwise noted, including written, print, photograph, audio/oral, interview, video, digital, televised, posted, streamed, and other electronic forms

_____

Description of Protected Health Information to be Used or Disclosed:

- All Patient Identifying Information, including:
- Patient Image
- Name
- Age/Date of Birth
- City of Residence
- Nature of Injuries/Illness

This Authorization applies to all dates of service, unless limited as follows:

Dates: From _____ **To** _____

PATIENT'S RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to CHS Corporate Communications, Outreach, and Marketing at PO Box 32861, Charlotte, NC 28232. Any cancellation will apply only to information not yet released by CHS under this Authorization.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **CHS will not share or use my health information without my permission other than by ways listed in CHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.**
- **I have a right to receive a copy of this form.**

This permission will continue until Carolinas HealthCare System no longer needs my information for the purposes stated above.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature: _____ **Print Name:** _____ **Date:**_____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☐ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** _____