Authorization to Use and Disclose Protected Health Information

Golden Opportunity
Project Title

/ /2025

Name of Patient / Participant | **Date**

Street Address | **Email**

City, State, Zip | **Phone Number**

Are you vaccinated against COVID-19?
Yes _____ No _____

☐ **DO NOT USE MY PHOTO**

Check off items being released to Ochsner Health System for the purpose of public relations, business development, sales, and internal and external marketing activities:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation Reports
- ☐ Pathology Reports
- ☐ Laboratory
- ☐ Cardiology
- **X Photographs/Video**
- ☐ Clinic Visit
- ☐ Hospital Admission
- ☐ Abstract ( )
- ☐ Dictated Letter
- ☐ Operative Report
- ☐ X-ray Report
- ☐ ER Record
- ☐ Entire Record
- ☐ Other _____

The undersigned hereby authorizes or ratifies, in addition to the release of the above information, using quotes and testimonials, the taking and use of photographs, film, audiotape and/or videotape during treatment or other procedures including special events hosted by Ochsner Health System and its subsidiaries and affiliates for use by these institutions for the purpose of public relations, business development, sales, and internal and external marketing activities, including use by or for news media, and further authorizes the use of the undersigned's name with said photos, film, print or tape in advertising activities, television commercials or broadcasts, radio ads or broadcasts, onsite vehicles (plasma screens, kiosks, etc.), print ads, annual reports, brochures, web sites, online outlets, outside billboards, business communications, books, scientific or industry papers, internal communications, e-newsletters, email marketing, social media platforms or outlets (including but not limited to mobile/smart phones, Facebook, Twitter, YouTube, Flicker, etc, and/or any digital technologies, including those not known today.)

In authorizing the release of the confidential information identified above, I hereby waive all restrictions or privileges imposed by law and release Ochsner Health System and its staff from any restriction or privilege imposed by law in connection with the disclosure or

release of any professional record, observation, or communication. I do understand that the information that is being released may be subject to re-disclosure by the recipient and may no longer be protected. I understand that my treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.

This authorization may be revoked in writing at any time, except to the extent that Ochsner Health System has already taken action in reliance on it. Letters to revoke this authorization should be addressed to Ochsner Health System, Release of Information Department, 1514 Jefferson Highway, New Orleans, LA, 70121.

If not previously revoked in writing, this authorization will expire three years from the date listed on this document.

If expiration date is left blank, authorization will expire within three years.

_____ / /2025

Print of Participant or Authorized Representative ***Date Signed***

_____ / /2025

Signature of Participant or Authorized Representative ***Date Signed***

_____

Relationship to Participant

_____ / /2025

Witness Signature ***Date Signed***