Intermountain Health

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

Name: (Please print legibly) _____ Date of Birth: _____
Address: _____
Phone number: _____ Home: ☐ Cell: ☐ E-mail: _____

1. **Authorization**
   a. This Authorization and Release allows Intermountain Health 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 Health 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 Health's use of this information. (For more information about Intermountain Health's use of health information and your health-information Privacy Rights, ask for a copy of Intermountain Health'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 Health.
   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 Health 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): _____ _____