Penn Medicine

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION INCLUDING RECORDINGS

Patient Name: _____

Address: _____

Phone Number: _____

Date of Birth: _____

I authorize the agents, assigns, and employees of the University of Pennsylvania Health System and the Perelman School of Medicine (collectively "Penn Medicine") to use and/or disclose my protected health information for the following purposes:

Check all that apply and specifically describe the persons or class of persons to whom the disclosure will be made (e.g. attendees at CME conference, students in a class)

- ☐ External Education Purposes: _____
- ☐ Marketing and Publicity: _____
- ☐ Public Affairs: _____
- ☐ Development and Fundraising: _____

* Use/disclosure for research activities requires the completion of the Research Subject Authorization Confidentiality & Privacy Rights Form.

The information that may be used and/or disclosed includes demographic information and any photographs, videotapes, audiotapes or other recordings (collectively, "Recordings") made of my image or voice. I understand that these Recordings may include identifiable images of the face.

I understand that this authorization will expire in fifty (50) years from the date of execution. I further understand that I may revoke this authorization at any time in writing except to the extent that action has been taken in reliance on this authorization.

I understand that a Penn Medicine provider may not refuse to treat me because I refuse to sign this authorization.

I understand that once information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient(s), and it may no longer be protected by federal privacy regulations.

I give this authorization voluntarily and with full understanding of its nature.

_____ _____

Signature of Person Being Recorded Date