Appendix C

Authorization to Use and Disclose Protected Health Information (PHI) for Media/Marketing and Other Related Purposes

1. UCR Health may use my protected health information for the following purposes
   - ☐ Marketing (e.g. brochures, billboards, other advertisements, about UCR, UCRSOM or UCR Health)
   - ☐ Print or electronic media (e.g. television, newspapers, magazines, both print and electronic)
   - ☐ Videography
   - ☐ Media or entertainment consultants
   - ☐ Other (specify)
   - ☐ I authorize UCR, the UCR School of Medicine, and/or UCR Health to release my protected health information (PHI) to the following organizations (if applicable)

2. Types of PHI that may be used or disclosed

☐ All of the following	☐ Email address	☐ Diagnosis/Method of Treatment
☐ Name	☐ Date of Birth and/or Age	
☐ Address, City and State	☐ Photograph/Video Image	☐ Date(s) of Treatment
☐ Phone number	☐ Personal Story	☐ Other (specify)

3. Once my health information is disclosed to the public, including members of the news media, UCR cannot guarantee that the information will not be re-disclosed to others.
4. Recipients of my PHI may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my PHI.
5. I may refuse to sign or may revoke (at any time) this authorization for any reason and that refusal or revocation will not affect the commencement, continuation, or quality of my treatment at UCR Health.
6. This authorization does not expire unless a specific expiration date is set. **Experiation Date:** _____
7. I may, at any time, provide written notice of revocation to UCR, UCR SOM, or UCR Health. The revocation will be effective immediately upon receipt of my written notice. At that point, there will be no further distribution of the content. I understand that it may not be possible to recall or remove items that have been published or otherwise released to the public. **Initial** _____
8. The revocation will not have any effect on any action taken by UCR Health in reliance on this authorization before it received my written notice of revocation.
9. Questions regarding this authorization, the use of my PHI, or my desire to revoke this authorization should be addressed to UCR SOM Compliance and Privacy Office, 900 University Ave., Riverside, CA, 92521 or via email at compliance@medsch.ucr.edu.

Signature of Patient or Legal Representative	**Print Name**	**Date**

Patient name	**Date of birth**	**Your relationship to patient**

Home Address, City, State, Zip	**Phone**