Centura Health®

Patient Label

Patient Authorization to be Photographed and/or Interviewed
CHCR-007 rev. 03/18
Epic # 211003 – Authorization Photograph/Interview **Page 1 of 1**

Patient Authorization to be Photographed and/or Interviewed

Patient Name	Date of Birth	Last 4 of Social Security Number
Address	**City, State, Zip Code**	**Telephone Number**

Authorization: By signing below, I hereby authorize Centura Health and its affiliated facilities, agents, contractors, providers or associates to interview and/or take photographs of me. I understand that the term photograph may include, but not be limited to, videotape, videodisc, digital image and any other mechanical means of recording or producing visual images (hereinafter referred to as photographs). I also understand the interview session may involve, but not be limited to, audio tape, or other recording device, written recording or other mechanical means or medium to preserve the discussions (hereinafter referred to as interview material).

I understand and agree that the photographs and/or interview material may also be used and/or disclosed for any and all other purposes deemed appropriate by, Centura Health and its affiliated facilities, agents, contractors, providers or associates. Such purposes may include, but not be limited to, education, treatment, internal marketing (for example, photo displays within the facility), public relations, advertising, communication materials, promotional and marketing publications (including postings on an organization's website), and/or fundraising activities.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment in any health plan, or eligibility for benefits. I understand that I may revoke this authorization at any time in writing by contacting the designated Health Information Management department and completing a Revocation of Authorization form.

I agree to hold Centura Health and its affiliates, agents, officers, contractors, providers, directors, and associates, or designated third parties who are involved in the production, duplication, publication or any other use and/or disclosure of the photographs, and/or interview material harmless for any damages incurred by such use and/or disclosure of the photographs and/or interview material. I also understand that the photographs and/or interview material used and/or disclosed pursuant to this authorization may be re-disclosed by a recipient and can no longer be protected by the aforementioned parties.

In addition, I waive all rights to or conditions on the use and/or disclosure of these photographs and/or interview material that I may have pursuant to this authorization and for the consideration provided, I further waive any claim for payment or royalties related to the production, duplication, publication or other specified use and/or disclosure of such by Centura Health and/or any affiliated facilities, or any other party involved in the specified use and/or disclosure now or in the future.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless specified here: 12/31/2030 (insert date of check box below)

☐ When no further production, duplication, publication or reprint or any other use of the photographs and/or interview material is required by Centura Health or its affiliated facilities.

Compensation (if applicable): The participant will receive consideration in the amount of $ 0.00. Participant's initials: _____

SIGNATURE: _____ **DATE:** _____

Patient (Parent or Legal Guardian)

Name of individual signing on behalf of patient: _____

Relationship (if other than patient): _____

OFFICE USE ONLY

Name of individual who received request: _____ Date received: _____

Patient CEU # / CSN #: _____ / _____ Completion date: _____

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Centura Health®

Patient Label

Patient Authorization to Disclose Protected Health Information
CHCR-004 rev. 01/21
Epic # 1000 - HIM ROI Authorization

Patient Authorization to Disclose Protected Health Information

Patient Name	Date of Birth	Last 4 of Social Security Number
Address	**City, State, Zip Code**	**Telephone Number**

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency or patient named.

Release by: Centura Health
Facility
9100 E. Mineral Circle
Address
Centennial, CO 80112
City, State, Zip Code
HIM Phone/Fax Numbers

Release to: general public
Organization, Agency, Individual
Attn:
Address
City, State, Zip Code

Treatment Date(s): _____
Purpose: ☐ Further Medical Care ☐ Workers' Comp
☐ Personal Use ☐ Insurance ☐ Legal
☒ Marketing/Fundraising
☐ Other: _____

Type of Disclosure Authorized & Delivery Instructions:
☐ Provide copies of records to organization/agency/individual
☐ Mail records directly to address above
☐ Call to pick-up records: _____
☐ Fax records to: _____
☐ Send records via encrypted email to: _____

Pertinent Protected Health Information Allowed to be Included:

☐ Discharge Summary	☐ Radiology	☐ Special Studies	☐ Entire Medical Record
☐ History & Physical/Consult	☐ Outpt Record	☐ Medication Records	
☐ Operative Report	☐ Progress Notes	☐ Psych Health Records	
☐ Labs	☐ Physician Orders	☒ Other (specify): Name, location, photo/video, condition	

Psychotherapy Notes are distinct and may not be included with the disclosure of any other protected health information. A Patient Authorization to Disclose Psychotherapy Notes must be completed.

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management / Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.
I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.
Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified here: 12/31/2030
Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).
For Marketing/Fundraising Purposes Only, if applicable: I understand that Centura Health ☐ will ☒ will not receive remuneration, either direct or indirect, as a result of the marketing that I hereby authorize.

SIGNATURE: _____ **DATE:** _____
Patient (Parent or Legal Guardian)

Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law.

Relationship (if other than patient): _____ ☐ Power of Attorney ☐ Death Certificate

Name of individual signing on behalf of patient: _____

Verification: ☐ Drivers License # _____ ☐ Other Appropriate ID: _____

OFFICE USE ONLY: Attach copies of required identification.

Number of pages released: _____ Completion date: Delivery method: _____

Name of individual who received request: _____ Date received: _____

Patient Medical Record Number / Account Number: _____/_____