Media Authorization for the Use and Disclosure of Protected Health Information

Patient Name:	Date of Birth:	Social Security Number:
Patient Address:		Date:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I, or my authorized representative, authorize the use and/or disclosure of my protected health information ("PHI") as described below:

1. I authorize Community Home Health Care ("CHHC"), with corporate offices located at 1 Hillcrest Center Dr., Spring Valley, NY 10977, and CHHC's agents and representatives to disclose to its affiliates, media representatives, production companies, web designers, advertising agencies, photographers and/or public affairs staff members the following PHI about me about me and my condition for the purposes of publicity, advertising, marketing, promotion, education or publication in print, broadcast and electronic media: My likeness on photo, video and digital media.

2. My authorization applies **only** to the use of my likeness as set forth above.

4. **I understand and agree to the following**:

- I may refuse to disclose all or some of my PHI and signing this authorization is voluntary. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- New York State law requires that I specifically authorize any disclosure of HIV- and AIDS-related information, and this authorization does not permit CHHC to disclose any HIV- and AIDS-related information.
- The information authorized for release does not include alcohol or drug abuse testing and treatment records protected by Federal confidentiality rules.
- Except as otherwise set forth above, once my PHI is used and/or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s) and no longer protected by applicable privacy laws.
- This authorization is not a commitment from CHHC to use my PHI for purposes of publicity, advertising, marketing, promotion, education or publication in any manner or media and CHHC reserves the right not to use my PHI.
- I have the right to revoke this authorization at any time. I understand that my revocation will not be effective to the extent that action has already been taken based on this authorization. Unless revoked this authorization will expire in 10 years.

Signature of Patient (Personal Representative): _____
Printed Name (Relationship): _____
Witness Signature: _____