AUTHORIZATION FOR USE/RELEASE OF INFORMATION

_____ , _____:

(PRINT PATIENT NAME) (DATE OF BIRTH OR LAST 4 DIGITS OF SSN)

1. Person(s) authorized to use/disclose the information: I permit any authorized representative or agent of Trinity Health and/or **TRINITY HEALTH OF NEW ENGLAND** to share my private health information and related approved images and videos for the purpose of:

_____

_____

_____

2. I understand that the following person(s), organizations or businesses will receive the information either directly or indirectly and may share it, in turn (select only those applicable in this instance):

- ☐ Trinity Health and/or Trinity Health Of New England employees through internal and/or operational communications
- ☐ Print and/or broadcast media outlets and professionals
- ☐ Audiences, including readers and viewers of subsequent media coverage
- ☐ Other healthcare and/or government organizations
- ☐ Local, state and/or federal policymakers
- ☐ Researchers/educators considering the information for related purposes research or education.
- ☐ Other: (specifically describe): _____

3. Description of information that will be collected and may be used/disclosed (PHI, photograph, video testimonial, other):

_____

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4. Identification and compensation: I understand that I may be identified by name or otherwise identifiable when my image and/or information is shared. I understand that I will not be compensated in any way for participating in this agreement or for the use of my image or information. This ensures the integrity of any potential facility, physician or system endorsement, either implied or intentional.

5. Authorization for one (1) year: I authorize the storage, reuse and re-disclosure of my information over the course of one (1) year for the purposes stated above. I understand and agree that this authorization is valid for one year from the date of signing unless I cancel it in writing or in person. I understand that I may cancel this authorization at any time and the cancellation will prevent all future disclosures, internal or external. I can cancel by mailing, faxing or taking a letter in person to the Marketing and Communications department of Trinity Health OR Trinity Health Of New England. My contacts for a potential cancellation of this authorization, at this time, are: Fiona Phelan, Media Relations Manager, Trinity Health Of New England, 114 Woodland Street, Hartford, CT

6. Information no longer protected. I understand that if the person or entity that receives my information is not a health care provider or a health plan covered by federal privacy regulations, my information may be re-disclosed, re-used or modified and is no longer protected by state or federal privacy laws applicable to health care providers.

7. Signature Not Required. I understand that neither Trinity Health, Trinity Health Of New England nor any of its affiliates can

require me to sign this authorization as a condition of getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan.

8. Copy. I agree that I have received a signed copy of this Authorization.

Signature of patient, parent, guardian or legal representative (circle one)	If signed by other than patient, name of parent, Guardian or legal representative	Date
Street Address	Relationship, if patient is not signing	Witness
City, State, Zip	E-Mail Address (internal purposes only)	Phone