HIPAA RELEASE OF INFORMATION

Media Release Authorization Form

I, _____ hereby authorize **Austin Health Partners**, its duly authorized employees or agents, to publish the following personal health information/story: _____ (e.g., information relating to the diagnosis, treatment, and health care services provided or to be provided to me and which identifies my name and other personally identifiable information) to be used in print media, on the radio, TV, the OSC website, blog and on the following social media platforms: Facebook, Instagram, Twitter, Pinterest, and You Tube.

The following information about me will not be disclosed:
_____.

I understand that any personal health information or other information released via the social media platform(s) above may be subject to re-disclosure by such social media platform(s) and may no longer be protected by applicable Federal and State privacy laws.

This authorization is valid from the date of my/my representative's signature below.

I understand that I have a right to revoke this authorization by providing written notice to Austin Health Partners. However, this authorization may not be revoked if Austin Health Partners, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Patient: _____

Name of Patient/Legal Guardian: _____

Signature of Patient/Legal Guardian: _____

Date: _____