HIPAA Authorization to Use/Disclose PHI for Marketing, Public Relations and External Communications Purposes

CHCO Staff initials_____

Patient Name _____ **Date of Birth** _____

Parent/Legal Representative's Name _____ Phone Number _____ Email address _____

Address _____ City _____ State _____ Zip _____

Section 1: I hereby authorize **Children's Hospital Colorado (CHCO)** to use or disclose information, as described below, to the following: (please select all that apply)

☐ External Media (e.g., news stations, newspapers) ☐ Children's Hospital Colorado marketing purposes
☐ Children's Hospital Colorado internal/external publications ☐ Children's Hospital Colorado social media sites
☐ Other:_____

For the purpose of (please describe): General marketing and promotion of the Burn Camps Program.

Event or Story: Burn Camp

Information related to the following condition/diagnosis*: Burn injury

Section 2: Release method

☐ Appearance or interview on camera ☐ Photographs ☐ Video or audio
☐ Other:_____

I understand the following: This authorization will expire on December 31, 2024. I may choose to **revoke** this authorization at any time, except to the extent that action has already been taken to comply with it, by notifying CHCO in writing. Information disclosed pursuant to the authorization may be subject to **re-disclosure** by the recipient and is no longer protected by the HIPAA Privacy Rule. CHCO will still provide treatment and seek payment for services provided, whether or not I sign this authorization.

Some news outlets share information amongst themselves or with their national affiliates. Except for CHCO, these news outlets do not allow review of stories, videotape or photographs before publication. I will be provided a copy of this authorization upon fulfillment of the request. I do not expect to receive financial compensation or consideration of any kind for use of the story.

I understand that the story and related materials are the property of CHCO.

For MARKETING uses or disclosures: CHCO_____WILL_____WILL NOT receive financial remuneration.

***Patient signature required below to release these information related to the following conditions/diagnosis:**
Patient age **13 or older**: Reproductive health including pregnancy and sexually transmitted disease, HIV/AIDS, or drug/alcohol treatment information.
Patient age **15 or older**: Behavioral health or psychiatric care information.

X_____ _____ _____
Signature of Personal Representative **Date** **Signature of Patient** (when required)

☐ Parent or Legal Representative ☐ Power of Attorney ☐ Next of Kin of Deceased ☐ Executor of Estate

Children's Hospital Colorado
Affiliated with University of Colorado Anschutz Medical Campus

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Rev. 6/2016

Place Patient Identification Label Here