**HIPAA AUTHORIZATION TO USE/DISCLOSE**
**HEALTH INFORMATION TO THE MEDIA**

I authorize **St Charles Health System** to use and/or disclose health information about me, _____ (name of patient), as specified below, to:

> Reporters for local, state and national media publications, including newspapers and magazines, and to reporters for local, state and national television broadcast stations, or as otherwise specifically described: _____
> _____.

The purpose of the disclosure is at the request of the individual.

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

_n/a_ Information about my specific injuries or medical condition
_n/a_ Only general one-word condition
_n/a_ My medical prognosis
_n/a_ My age
_n/a_ My city, county or state of residence
_n/a_ The date and time of my expected or actual discharge from the hospital
_n/a_ Information necessary to conduct an interview with me in the hospital
_n/a_ Information necessary to take a photograph of me in the hospital
____ Appearance/interview by media on camera; still photos or video footage for use in publications and/or Web sites.

I understand that media representatives are not covered by federal privacy regulations and my health information may be re-disclosed and no longer protected by these regulations.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization.

Unless revoked earlier, this authorization will expire when I am discharged from the hospital.

Signature of patient or patient's Personal Representative Date

Print Patient's Name

Name of Personal Representative (if applicable) Relationship to Patient