Authorization for Use and Release of Information and Images for Communications, Marketing and Development Purposes

Patient/Individual Information (please print):

First Name: ____________________ Last Name: ____________________

Street Address: ____________________ City: ____________________

State: __________ Zip: ____________ Date of Birth (dd/mm/yyyy): ____________________

Email Address: ____________________

Legal Guardian (if any):

First Name: ____________________ Last Name: ____________________

Relationship to Patient (parent, guardian, etc.): ____________________

I give permission to Boston Medical Center (BMC) to photograph and record me. I also authorize BMC to use and release the details of my medical care and personal information, and images and recordings of me, in any format, to inform the public about BMC. I authorize BMC to share these images, recordings and information with the media, press and/or social media networks, who I understand may further share my information with others, including the general public. Once this information is shared, it is no longer controlled by BMC and may be re-disclosed by the recipient.

You have the right to take back your permission. You can email communications@bmc.org or write to: Marketing and Communications, 720 Harrison Ave., 6th Floor, Boston, MA 02118. However, if you take back your permission, it will not affect any actions we took based on the permission. For example, BMC cannot take back information that was already shown on TV, printed in a magazine or copied by someone from the internet.

Your participation is completely up to you. You do not have to agree to share your information. Your decision (either yes or no) will not affect your being able to get health care at BMC or payment for your health care.

SENSITIVE INFORMATION RELEASE AUTHORIZATION: If this authorization is for the release of sensitive information about you such as: substance use disorder; psychotherapy; HIV testing or test results; abortion services; sexually transmitted diseases; genetic test results; social worker communications; domestic violence victim counseling; sexual assault victim counseling; then we must get your specific consent to share that information with the public or external media outside of BMC. Information that is shared is no longer controlled by BMC.

Check this box ☐ if you agree to share sensitive information. Write the type of sensitive information on the line below:

____

42 CFR Part 2 is a rule that protects information related to specific substance use disorder treatment programs.

Check this box ☐ if this authorization is for the release of information related to a BMC 42 CFR Part 2 program and on the lines below (1) name the program and (2) describe the type of substance use disorder information that may be disclosed:

____

This Authorization will expire on*: ____________________
(*If no date is listed, this Authorization will expire 10 years from the date you sign unless you withdraw consent.)

I have read and understand the above document and have had any questions explained to my satisfaction. I have received a copy of this form.

Sign Name: ____________________ **Print** Name: ____________________ Date: ________ Time: ________
Patient

Sign Name: ____________________ **Print** Name: ____________________ Date: ________ Time: ________
Parent/Guardian/Surrogate (if applicable)

I interpreted the provider's explanation. (Interpreter must sign below, if applicable)

Sign Name: ____________________ **Print** Name: ____________________ Date: ________ Time: ________

For internal use

BMC staff: ____________________ Event or purpose: ____________________

Phone/email: ____________________ Date of recording: ____________________

Location: ____________________ Patient description: ____________________