



National Association of Community Health Centers (NACHC)
HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION: AUDIO/VISUAL RELEASE FORM

By signing below, I authorize NACHC to use and share the following personal information: My picture (including photographic, motion picture, and electronic (video) images); My voice (including sound and video recordings); and My story (including name and treatment information in full, summary, or edited form, and/or in combination with other text, images, or recordings).

I hereby grant to NACHC and others NACHC may give rights or permission to, the right to use, publish, and reproduce, for all marketing, communications, and/or educational purposes the personal information described above to or in any and all media including, without limitation, cable and broadcast television, the Internet, radio, or podcast, newspapers, magazines, and/or and for exhibition, distribution, promotion, advertising, sale, press conferences, meetings, hearings, educational conferences and in brochures and other print media. This authorization extends to all languages, media, formats and markets now known or hereafter devised.

I further agree that NACHC shall have all right, title, and interest in all text, images, sound records, videos or other items created as a result of this authorization (including finished pictures, negatives, reproductions, and copies of the original print) and further agree that NACHC shall have the sole right to give, sell, transfer, and/or exhibit the print in copies or facsimiles thereof, for marketing, communications, or advertising purposes, as it deems fit.

I hereby waive the right to receive any payment for signing this authorization and waive the right to receive any payment NACHC's use of any of the material described above for any of the purposes authorized by this release. I also waive any right to inspect or approve finished photographs, audio, video, multimedia, or advertising recordings and copy or printed matter or computer generated scanned images and other electronic media that may be used in conjunction therewith or to approve the eventual use of any such materials.

I give this authorization freely with the understanding that: (a) I may refuse to sign this authorization; (b) I may revoke this authorization at any time (by sending written notice to NACHC's Communications Department at communications@nachc.org except where information has already been released in reliance on my authorization; (c) NACHC may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization; (d) a photocopy or fax of this authorization is as valid as the original; NACHC, its directors, officers, employees, agents and volunteers, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein; (f) any information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law; and (g) I may request a copy of this signed authorization.

Unless otherwise revoked by me, this authorization expires ten (10) years from the date that I sign it.

I acknowledge that I have read the foregoing and I fully understand the contents.

IN WITNESS WHEREOF, I have executed this release on this ___ day of ___, 20__.

Print Name: _____ Signature: _____

Address: _____ Telephone Number: _____

City/State/Zip: _____ E-mail Address: _____

If the person signing is under age 18, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____, and do hereby give my authorization without reservation to the foregoing on behalf of this person.

Parent/Guardian's Signature Date

Parent/Guardian's Printed Name Date