Authorization to Use or Disclose Protected Health Information ("PHI") for Marketing, Fundraising or Media Relations

For Use by communications staff or Approved Designee.
Employee Name:

Patient Name	Date of Birth	Health Record Number
Patient Mailing Address	Patient Phone Number	Patient E-mail

Name of Requestor (if other than patient)	Relationship to Patient (if other) ☐ Parent ☐ Legal Guardian ☐ Other:
Requestor's Address & Phone Number	Verification of Identity: ☐ Personally known ☐ Driver's License/State ID ☐ Other:

By signing this form, I grant permission for UF Health* to do the following:

Disclosure (sharing) of PHI to: Person, Organization, News Media Outlet, Event or Campaign	Mailing Address
Phone	E-mail

What PHI may be shared? *Check all that apply*

☐ Name ☐ Diagnosis/Condition/Treatment ☐ Services provided
☐ Treating provider/specialty ☐ Treatment location ☐ Photo or video
☐ Personal story/Testimonial ☐ Artwork ☐ Medical images or recordings
☐ Other (describe):

Sharing of highly-confidential information:
Check all that are approved
☐ Mental Health/Psychiatric Treatment
☐ Alcohol, Substance or Drug Treatment
☐ Sexually Transmitted Disease Treatment
☐ HIV or AIDS Treatment(s) or Test(s)

What is the Purpose of Sharing the PHI? *Check all that apply*
☐ Marketing ☐ News Media ☐ Public Relations ☐ Publication (e.g., brochure, online journal, book) ☐ Fundraising
☐ Other (describe):

***Marketing** means to make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. **Fundraising** means to make a communication about a product or service that encourages recipients of the communication to provide charitable gifts or funds to UF Health.*

Notification of Payment for Use of PHI for Marketing Purposes *To be completed by communications staff or designee*

☐ Check this box only if UF Health will receive financial remuneration (i.e., payment) in exchange for making a marketing communication.

- This authorization permits UF Health to use and disclose (share) certain protected health information (PHI). By signing this authorization, I am giving permission for UF Health to use and share PHI for a specific purpose or use as I have directed. The PHI may include information about mental health, substance and/or alcohol abuse, HIV/AIDS or sexually transmissible diseases.
- I understand that the PHI checked above will be shared publicly. I understand that PHI shared per this authorization may no longer be protected by state law or the federal health privacy law and that the PHI could be re-disclosed by the person or entity that receives it. I hereby release and discharge UF Health, all of their successors, and all persons acting under their permission and authority from any liability that may arise from the release of PHI as I have directed.
- I understand that this authorization will remain in effect until I revoke it in writing. I understand that I have the right to revoke this authorization (i.e. tell UF Health to cancel it) by providing a written statement to the UF Health Privacy Office at P.O. Box 103175, Gainesville, FL 32610-3175, or to Privacy@shands.ufl.edu, or fax to 352.627.9052. The revocation will not apply to any PHI already released as a result of this authorization.
- If I refuse to sign this authorization, doing so will not affect my treatment or payment, my enrollment in or eligibility for benefits, or the quality of care that I receive. I understand that I waive any right to inspect and/or approve the final product. I also understand I will not be paid money or receive other compensation for using or sharing PHI.

*For purposes of this authorization, UF Health includes the University of Florida Board of Trustees for the benefit of the University of Florida College of Medicine, Shands Jacksonville Medical Center, Inc., and Shands Teaching Hospital & Clinics, Inc.

Printed Name	Date
Signature of Patient or Patient Representative	**Relationship to Patient (if other):** ☐ Parent ☐ Legal Guardian ☐ Other:

UFHealth
UNIVERSITY OF FLORIDA HEALTH

HI0001

Patient Name: Patient Identification #:

Revised 8/3/18 PS15652