Sample Authorization to Use/Disclose Health Information to the Media:

AUTHORIZATION TO USE/DISCLOSE MENTAL HEALTH INFORMATION TO THE MEDIA

I authorize [Practice name] to use and/or disclose mental health information about me, as specified below, for _____ (name of patient) 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: _____
_____
_____

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

- ❒ Information about my specific illness or emotional condition
  Only general one-word condition
- ❒ My prognosis
  My age
- ❒ My city, county or state of residence
- ❒ The date and time of my expected or actual discharge from treatment
  Information necessary to conduct an interview with me while in treatment
  Information necessary to take a photograph of me while involved in treatment
- ❒ Such other information as described here: _____

I understand that media representatives are not covered by federal privacy regulations and my mental health information may be redisclosed 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 ahs been taken in reliance upon this authorization.

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

_____ _____

Signature of patient or patient's Personal Representative Date

_____

Print Patient's Name

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient