Patient Release

PUBLIC RELATIONS
PATIENT AUTHORIZATION FORM

I hereby agree to allow Indiana Regional Medical Center ("the Medical Center") and parties designated by it to use (1) my photograph (still, motion picture, or video), (2) audio recordings of my voice, and (3) any written information I may provide for publication in any audio, video, or print media, including newspapers, magazines, billboards, brochures, other printed media, the Medical Center's web site, radio advertisements, or television broadcasts.

I understand that the information described above will be used for the benefit of the Medical Center and its community relations and/or fundraising programs, and that such use will be in good taste.

I understand that I am not required to sign this authorization form in order to receive treatment from the Medical Center. I understand that I may refuse to sign this form.

I understand that signing this form may cause certain health information about me to lose its protections under the federal privacy laws and perhaps be re-disclosed to other parties. For example, individuals who see an advertisement with my photograph will know that I received health care treatment at the Medical Center. However, I also understand that the Medical Center is prohibited by law from disclosing other health information about me without my consent.

I understand that I may revoke this authorization form at any time, in writing, except to the extent that the Medical Center has already relied upon it in making a disclosure. My written revocation will become effective when the Medical Center has knowledge of it. Written requests for revocation are to be sent to the Privacy Officer of the Medical Center at: 835 Hospital Road, Indiana, PA 15701.

This Authorization form expires one year from the date on which it was signed. Once this Authorization has expired, the Medical Center may no longer use or disclose my health information for the purpose listed in this Authorization unless I sign a new Authorization form.

Date _____ Signature of Patient _____
If patient is unable to sign:

Date _____ Personal Representative of Patient _____
Description of Personal Representative's authority to act for patient:

IRMC