Hocking College
Patient Consent to Photograph/Film/ Interview and/or Authorization to Release Protected Health Information

HOCKING COLLEGE
3301 Hocking Parkway
Nelsonville, Ohio 45764

Patient Name (print): _____ **Date of Birth:** _____

Person(s) or Class of Persons Authorized to Use/Disclose the Information:
Hocking College

Person(s) Authorized to Receive the Information: _____

Patient consents to be:

☐ Photographed ☐ Filmed ☐ Interviewed (including audio recording)
☐ Other: _____

Description of Protected Health Information to be Used or Disclosed:

☐ All patient identifying information
OR
☐ Age/Date of Birth
☐ City of Residence
☐ Nature of injuries/illness
☐ Other: Name, photo, condition and treatment related to story
☐ Not applicable

I understand that, in the instance of external sources (such as media outlets or law enforcement agents), the Hocking College facility is acting only as the intermediary, making it possible for the aforementioned source(s) to contact me.
As such, I relieve and hereby agree to hold Hocking College Marketing, Public and Community Relations and/or Hocking College and the facility free and harmless from any and all liability arising out of the use and/or release of information; interview; photograph/videotape/film; and subsequent publication or broadcast. I understand that the interview(s) or photo session(s) are being carried out upon my consent and authorization and so assume full responsibility.
I understand that:

1. I may refuse to sign the authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may be redisclosed by the recipient and may no longer be protected by federal privacy regulations.
5. I understand that I may see/obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected helath information as stated.

Signature of Patient/Guardian/Patient Representative or Employee/Volunteer/Physician: _____ **Date:** _____

Print Name of Patient's Representative: _____ **Relationship to Patient:** _____