HENRY FORD HEALTH℠

Authorization to Use/Disclose Photo, Video, Audio Recording, and/or Related Medical Information

Place patient label here or fill out information below:

Patient Name: _____

Date of Birth: _____

MRN: _____

I understand that signing this authorization form means I give permission to Henry Ford Health (HFH) to use personal information about my health and healthcare. **Please fill out all the following:**

Name: _____ Are you a HFH patient? ☐ Yes ☐ No

Address: _____

Phone: _____ Email: _____

Check the boxes that apply:

☐ **I give permission** to HFH to tell my patient story, take my photo, to be videoed/livestreamed, and have my voice recorded for these purposes:

- News media (newspapers, radio, TV, online media, etc.)
- HFH internal news (HFH Morning Post, OneHenry, etc.)
- HFH marketing and/or advertising (billboard, brochure, radio/TV commercials, etc.)
- HFH patient and/or medical training (HFH diabetic teaching guide, etc.)

Assignment Project: _____

PR/Marketing Representative: _____

☐ **I give permission** to HFH to take/use/disclose my photo, video, audio recording/livestreaming, and related medical information for treatment and healthcare operations purposes, including internal education and training.

Department Representative: _____

☐ **I give permission** to HFH to take/use/disclose my photo, video, audio recording/livestreaming, and related medical information for external education (journals, publications, presentations, etc.)

Department Representative: _____

☐ **I give permission** to HFH to take/use/disclose my photo, video, audio recording/livestreaming, and related medical information for use by a HFH healthcare professional for their personal and professional social media sites (Facebook, X, Instagram, YouTube, LinkedIn, Doximity, etc.)

Department Representative: _____

Authorization

I understand and agree to the following:

- No one will be paid for use/disclosure of my photo, video, audio recording/livestreaming, and related information.
- Signing this form will not change my healthcare. This form will be scanned to my health record or sent to the HFH Privacy and Security Office to be kept on file.
- This form is valid for 5 years from the date it is signed.

How to Take Back an Authorization

- I know that I can take back (revoke) this authorization at any time.
- If I change my mind about my patient story, photo, video, or audio recording/livestreaming, I must tell HFH in writing by emailing PrivacySecurity@hfhs.org or by mail to: Henry Ford Health, Information Privacy & Security Office, One Ford Place, Detroit, MI 48202.
- Even if I change my mind, I understand that HFH cannot undo use of my patient story photo, video, audio recording/livestreaming, and related information that already happened. Once that occurs, my information may be re-disclosed by a third party outside of HFH and not be protected by patient privacy laws.

I have read and understand the authorization above. I was able to ask all of my questions, and they were answered.

_____	_____	_____
Patient or Legal Representative Signature	Date	Time

☐ Check if interpreter was used. _____
Interpreter Name and Phone Number

For HFH Use Only

If authorization is for internal/external education, scan signed from to EPIC medical record.
If authorization is for PR/Marketing purposes, send signed form to privacysecurity@hfhs.org

Privacy Security Use Only:

Received by: _____ Date Received: _____ Expiration Date: _____