AUTHORIZATION FOR TRAINING, MEDIA, PUBLIC COMMUNICATIONS, FUNDRAISING OR MARKETING PURPOSES

☒ I authorize UCDHS to use or disclose the following health information, including medical record information, photographs, videos or other images:

My Participation in the Drive-thru Fall Festival
(type of information)

☒ I agree to be interviewed

☒ I agree to be photographed or videotaped

Specify the date or time period for information above:

I authorize **UC Davis MIND Institute, UC Davis Health and Public Affairs**
(persons or organizations)
to receive this information for the following purpose(s):

☒ News story (TV, radio, newspapers, magazines). Purpose/topic: **Fall Festival**
☐ My use or by anyone I designate. Name: _____
☐ Training of health care professionals, including students, faculty, and others (CME, classroom lectures, medical journals). Identify: _____
☒ Health care communications and other stories that will be seen or read by the public. Identify: **UCDH, Web sites and Social Media platforms**
☐ Fundraising activities to raise funds for _____
☐ Marketing activities that provide your information to outside third parties, business or companies so that they can contact you to sell their product.
The University: ☐ will receive remuneration for this marketing
☐ will not receive remuneration for this marketing
☐ Other _____

If applicable, and if checked below, I specifically acknowledge that the information used or disclosed pursuant to this Authorization may include the following types of sensitive medical information:

☐ AIDS/HIV test results
☐ Mental health diagnosis or treatment (other than psychotherapy notes)
☐ Genetic testing information and/or records
☐ Drug and alcohol diagnosis and treatment information

☐ Check here if you do not wish to be identified by name.

Please identify any other restrictions: _____

NOTICE

UCDHS and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

Your authorization to use or disclose your health information is voluntary. Your treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing or refusing to sign this Authorization.

You may revoke this Authorization at any time. The revocation must be in writing, signed by you, and delivered to Health Information Management Department, UCDHS, 2315 Stockton Blvd., Building 12, Sacramento, California 95817. The revocation will take effect when UCDHS receives it, unless UCDHS or others have already relied on it.

EXPIRATION

Unless otherwise revoked, this Authorization expires 2030 (insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of signing this form.

SIGNATURE

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed Name Time: AM/PM

_____

(if signed by someone other than the patient, state your legal relationship to the patient/authority)

_____

Witness (only if patient unable to sign) or Interpreter