Stony Brook Southampton Hospital

Authorization for the Use and Release of Patient Photographs and Video

I hereby authorize the use and disclosure of my photo(s) and/or video as described below. I understand that this authorization is voluntary. I also understand that if a person or organization authorized to use my photo(s) and/or video is not a health plan or health care provider, the released information may be subject to re-disclosure and may no longer be protected by the federal privacy regulations.

Patient name (please print): _____

Persons/organizations authorized to use my photo:
Stony Brook Southampton Hospital

Persons/organizations who may receive information including my photo:
Local press, Hospital publications, Hospital website and Internet media

The photo of me taken by Stony Brook Southampton Hospital or its representative(s) will be used for an indefinite period of time.

Description of each purpose of the use or disclosure of my patient information:
My photo(s) and/or video taken by Stony Brook Southampton Hospital or its representative(s) will be used for public relations and/or marketing purposes. The public relations and/or marketing purposes which this authorization is being requested will not involve direct or indirect remuneration from a third party to Stony Brook Southampton Hospital.
The following conditions will be applicable:

1. This authorization has no expiration date and my photo may be used indefinitely.
2. I may refuse to sign this form and my health care and the payment for my health care will not be affected if I do not sign this form.
3. I may request a copy of this form after I sign it.
4. I may revoke this authorization at any time by notifying the Hospital in writing, but if I do, the revocation will not have any effect on actions the Hospital has already taken with regard to this authorization.

Complete the following, if this authorization is signed by a patient's representative:
Name of patient's representative: _____
Relationship to the patient: _____
Describe the representative's authority to act for the patient: _____
_____

_____ _____
Signature of patient or patient's representative **Date**

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION