AHRC Suffolk, 2900 Veterans Memorial Highway, Bohemia, NY 11716

HIPAA Authorization for the Use or Disclosure of Information for Publications, Videos, and Photos (HIPAA-2PC)

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your personal information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

PART 1 - PLEASE PRINT NAME CLEARLY

Name of Person Supported by AHRC Suffolk:_____, _____
(Last name) (First name)

Date of Birth:_____/_____/ _____

PART 2 - Use and Disclosure Covered by this Authorization

You or your personal representative should read the descriptions below before signing this form.

Who will disclose the information? AHRC Suffolk

What information will be used? AHRC Suffolk **may disclose the following, as pertains to the person named above: full name; photos, videos, and other likenesses; quotes; artwork, music, writings, or other creative work; the name of the person's AHRC Suffolk program or residence**

AHRC Suffolk regularly publishes the following types of communications, each of which are viewable by the public: news articles, photos, videos, email newsletters, websites, social media venues, promotional materials including brochures. AHRC Suffolk also supports people to display their artwork, music, and other creative work.

Who will use and/or receive the information? The general public and media outlets.

What is the purpose of the use or disclosure? The purpose of the use of this information is marketing, fundraising, and raising public awareness of AHRC Suffolk and its mission while celebrating the achievements of people who benefit from AHRC Suffolk's services and supports.

Please note that to the extent AHRC Suffolk has published the information that you choose to authorize for public distribution, the released information may be re-disclosed and may no longer be protected by federal privacy regulations.

Expiration of Authorization: This authorization will be in effect until you revoke it or if you choose to be discharged from all AHRC Suffolk programs.

Compensation Details: AHRC Suffolk will not receive financial or in-kind compensation in exchange for the publications, photos, videos or creative work.

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your personal information as described above. Please note that once the authorized information has been published, AHRC Suffolk may no longer be able to control who receives the information, or what they do with it. In that event, such information may no longer be protected by the federal HIPAA privacy regulations.

1. I understand that I will not receive any payment or compensation for the use or disclosure of the information about me that I have authorized for publication purposes by signing this document.
2. I may revoke this authorization at any time by calling AHRC Suffolk's Privacy Officer at **631-585-0100** to notify him/her of my choice to revoke authorization, however; to the extent that the previously published information has already been distributed, it will not be possible to stop the continued use of information which has already been made public.
3. I understand that if I choose to revoke my authorization after information about me has already been published, AHRC Suffolk will honor my request to not include my information in future publications.
4. Releasing information to the public means that the information has the potential to be further distributed by people who are not affiliated with AHRC Suffolk. I understand that if the person or entity authorized to receive my health and clinical information is not a health care provider or health plan, the released information may be re-disclosed and may no longer be protected by federal privacy regulations.
5. I may refuse to sign this form authorizing the release of protected health information and my refusal to sign will not affect my ability to obtain treatment.
6. I may, in accordance with any applicable agency Privacy Policy, inspect or copy any information used or disclosed under this authorization upon request and obtain a copy of this form if I ask for it.

PART 3 - Signature and Date

I have read this form and all of my questions about this form have been answered.
By signing below, I acknowledge that I have read and accept all of the above.

Signature of person supported or his/her representative _____

Date of Signature:_____/_____/ _____

If consent is provided by a representative, please clearly print the name of the representative and his/her relationship to the person

Full name of representative: _____

Relationship to the person named on this form: _____

PART 4 - Contact Information

It may be necessary for AHRC Suffolk to contact the person signing this form if we have further questions.

Phone Number:_____ **Address:** _____