AHRC Suffolk
2900 Veterans Memorial Highway
Bohemia, NY 11716

AUTHORIZATION TO BE AUDIO / VISUALLY / DIGITALLY RECORDED

Name (Please Print): _____ Date of Birth: _____

Address: _____ Telephone Number: _____

City: _____ State: _____ Zip: _____

AHRC understands that information about you and your health is personal and we are committed to protecting the privacy of that information according to the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Because of this commitment, we must obtain your authorization before we use or disclose your information for the purposes described below. This form provides that authorization and helps us ensure that you are properly informed as to how this information will be used or disclosed. Please read the information below carefully before signing this form.

USES AND DISCLOSURES COVERED BY THIS AUTHORIZATION

DO NOT SIGN A BLANK FORM. You or your personal representative should read the descriptions below before signing this form.

1. Permission

I, _____, hereby give my consent to the taking or making of photographs, audio recordings, video recordings, digital recordings, films and/or media interviews of me or the above-named person by AHRC Suffolk personnel or contractors, news media organizations, or any person, firm or organization that may be designated or authorized by AHRC Suffolk, in connection with the services which I or the above-named person am receiving or have received at AHRC Suffolk. I further consent that broadcast, audio, video, or digital recordings or verbal discussions about the history of medical, mental health and social problems of me or the above-named person and/or such problems may be taken by AHRC Suffolk personnel or contractors, news media organizations, or any person, firm, or organization that may be designated or authorized by AHRC Suffolk.

2. Permitted Uses

I have freely consented to the use by AHRC Suffolk personnel or contractors, news media organizations, or any person, firm or organization that may be designated or auhorized by AHRC Suffolk of such photographs, audio recordings, video recordings, digital recordings, histories, films, and/or media interviews and understand and agree to the following such uses, publication, and/or exhibition related to AHRC Suffolk (please specify):

_____ Advertising

_____ Brochures

_____ Release to news media

_____ AHRC Suffolk Website and Social Media

_____ Educational, instructional or teaching purposes

_____ Newsletters and Publicity

_____ Fundraising publications

_____ Other (please explain): _____

3. Identification

I understand, agree and consent that I, or the above-named person, may be identified by name or other identifying characteristic in connection with any public use of this material.

4. Waiver of Royalties

I do hereby waive any and all rights the above-named person or I may have to the materials and royalties or other compensation in connection with the publication or other use of the materials.

5. Duration

This authorization shall remain valid unless and until I revoke the authorization.

6. Specific Understandings

By signing this authorization form, you authorize the use or disclosure of your information only as described above. To clarify, you do not authorize the disclosure or re-disclosure of any protected health information for any purposes other than to be audio/visually/digitally recorded for the purposes identified in #2 of this release. This information may be re-disclosed if an individual receiving the audio/visually/digitally recorded materials not required by law to protect the privacy of the information, and in that event such information may no longer be protected by the federal HIPAA privacy regulations.

You have a right to refuse to sign this authorization. Your health care, the payment of your health care, and your health care benefits will not be affected if you do not sign this form. You have a right to see and copy the information described on this authorization form. You also have a right to receive a copy of this form after you have signed it. If you sign this authorization, you will have the right to revoke it at any time, except to the extent that AHRC Suffolk has already taken action based upon your authorization. To revoke this authorization, please write to AHRC Suffolk's Privacy Officer at 2900 Veterans Memorial Highway, Bohemia, NY 11716.

If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from re-disclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have the right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights, which is the agency responsible for protecting your rights.

7. Signature

By signing below, I acknowledge that I have read and accept all of the above.

_____

Signature of Person or Personal Representative (parent, guardian or individual authorized to consent to the use or disclosure of information)

_____

Date

_____

Print Name of Person or Personal Representative

_____

Relationship to Person (if applicable)

8. Witness

_____

Signature

_____

Date

_____

Print Name