HIPAA & MEDIA RELEASE AUTHORIZATION FORM

I hereby authorize Advocate Radiation Oncology and its duly authorized employees or agents, to publish the following personal health information or story that contains my name or likeness.

This photo or story may contain information relating to the diagnosis, treatment, and health care services provided or to be provided to me by Advocate Radiation Oncology and identifies my name and other personally identifiable information. This information may be used in print media, on the radio, TV, Advocate Radiation Oncology website, blog and on the following social media platforms: Facebook, Twitter, Instagram, and YouTube.

I understand that any personal health information or other information released via the social media platform(s) above may be subject to redisclosure by such social media platform(s) and may no longer be protected by applicable Federal and State privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to ARO. However, this authorization may not be revoked if Advocate Radiation Oncology, its employees, or agents have acted on this authorization prior to receiving my written notice.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to seek treatment with Advocate Radiation Oncology, eligibility for benefits or enrollment or payment for or coverage of services.

Lastly, I understand I will not be compensated for the use of any images or my likeness that is used in any social media platforms. I also understand that Advocate Radiation Oncology and it' s duly authorized employees or agents are not liable to notify photographers/agencies of the use of these photos, and it is between myself and the photographer to discuss the distribution rights of any images.

_☐_I agree and give my permission to the above stated information.

_____ _____

Printed Name Signature

Signature of parent/legal guardian/personal representative:

_____

(if patient or subject is under the age of 18 or otherwise incapable of signing)
If personal representative, please print name and state relationship to patient

_____

Phone Number

Date: _____ / _____ / _____

To send the form, please save the signed form to your computer or phone and then attach the document to the email and send to skubesh@advocatero.com.