



AUTHORIZATION/CONSENT FOR USE OR DISCLOSURE OF INFORMATION FOR PUBLICATION PURPOSES

Part I. Name of Individual	
Event or Program	
Name: Last First MI	Last 4 digits of Social Security Number:
Address:	Date of Birth:
	Phone Number: ()

Part II. Authorization for Use and Disclosure of Information, including Protected Clinical Information :

authorizes OPWDD to use or disclose the following information about you:
Describe the information to be used or disclosed (check all that apply):

Dates of service (if applicable):

Photographs or other likenesses of me
 My name
 My residence or program attended
 Other, please describe:

For the publication purposes described below:
Describe the purposes for use or disclosure (check all that apply):

Posting on the OPWDD Internet Website
 Publication in an OPWDD Newsletter or other format for public distribution
 Release to Media
 Training materials, including video recordings
 Other (please describe)

Note: the following must be completed by health care providers or health plans requesting the authorization:
 Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health or clinical information described above?

No Yes

Part III. Signature and Date:

1. I understand that I will not receive any payment or compensation for the use or disclosure of any photographs or likenesses of me or the use or disclosure of any other information about me for the publication purposes I have authorized in this document.

2. I may revoke this authorization, in writing, at any time by notifying the person or entity I have authorized to use or disclose information as listed above.

3. I understand that a revocation is not effective against actions taken by the person or entity named above before they received such revocation and to the extent that they have relied upon this authorization.

4. 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 redisclosed and may no longer be protected by federal privacy regulations.

5. I may refuse to sign this form authorizing release of protected health information and my refusal to sign will not affect my ability to obtain treatment or payments except in some situations when such information is needed for payment and enrollment.

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.

<i>Signature of individual or representative</i>	<i>Date</i>
<i>Print name of Individual or representative</i>	<i>Representative's relationship to Individual</i>

This Authorization Expires:
(insert date or event)

A Copy of this signed form shall be provided to the Individual or Representative.