LEHIGH VALLEY HEALTH NETWORK
PATIENT AUTHORIZATION FORM for MEDIA PARTICIPATION

Print Name:_____

Address:_____ **City/State:**_____

Email Address: _____

Phone: (Work)_____ **(Home)**_____

Lehigh Valley Health Network (LVHN) is requesting _____to authorize the use and disclosure of confidential information to selected media for the following purposes:

List the purpose: taking and public use of any photographic, audio visual or other media recordings or written articles by a person selected by Lehigh Valley Health Network and its affiliates/subsidiaries.

List the information that is to be disclosed: person's name and photo, and person's medical information as is relevant to the publication or media entity

Location and description of photo:_____

_____

Conditions:

- The undersigned agrees that the above named individuals/organization may access his/her confidential information only for the purpose listed above. The information disclosed pursuant to this authorization will not be redisclosed by the recipient for any other purpose.
- The undersigned consents to the use of his/her name and image in any hospital related publications, Web site or projects. The undersigned waives any right that he/she may have to copyright, inspect, or approve the finished project that may be used hereunder, or the specific use or context to which it may be applied. The undersigned releases Lehigh Valley Health Network, its components, employees, agents and medical staff from any liability connected with the taking or use of these audio or visual recordings or representations.
- The undersigned is voluntarily signing this authorization.
- The undersigned understands that it is **not** necessary to sign this form as a condition of receiving treatment, and it has no effect on payment activities related to services rendered or eligibility for benefits. The undersigned will not receive compensation for this authorization.
- Once the undersigned gives authorization, we can rely on it until it is revoked or until it expires. The revocation must be in writing and forwarded to _____. The revocation will be effective immediately upon receipt of written notice of revocation, however, will not prohibit us from any disclosures we have made or acts we have already taken in reliance on the authorization.
- The undersigned may request a copy of the signed authorization.
- The authorization will be maintained by Lehigh Valley Health Network for a period of six (6) years.
- This authorization is in effect for three (3) years from the date of signing. Upon the conclusion of that time period, this authorization is automatically revoked and no further use of the confidential information is permitted beyond that date.

Signature:

_____	_____	_____
Signature of Subject	Witness	Date
_____	_____	_____
Authorized Representative	Relationship	Age of child if a minor

For Internal Use Only: Publication/Date:_____