



THE TEXAS HEART INSTITUTE®

CENTER FOR CARDIOVASCULAR CARE

**HIPAA AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION
AND CONSENT/USE OF PHOTOGRAPHS AND AUDIO/VIDEO IMAGES**

The Texas Heart Institute Center for Cardiovascular Care (“THICCC”) is always pleased when patients are willing to communicate the stories, experiences, and information about their treatment provided by THICCC. Sharing your story can help others who are interested in knowing more about the patient services provided by THICCC health care providers, and also help THICCC further its mission to fully integrate patient care with innovative cardiovascular research and education in order to share THICCC’s learnings with others.

THICCC respects the privacy of our patients. Ensuring that medical information is kept confidential in accordance with applicable state and federal laws including Health Insurance Portability and Accountability Act of 1996, better known as HIPAA, is among our highest priorities. THICCC seeks your permission to use your medical information and your consent to allow us to take and use audio/video/photographic material of you in THICCC’s internal and external communications, including medical and general interest publications and medical and patient education information, and distribute such materials online, in print, and in news media (such as TV, radio, newspapers, and magazines).

To ensure that THICCC is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to fill out and sign this form. THICCC will keep a copy of your written authorization on file.

- I give my permission for THICCC to use my or my child’s name and share details of my or his/her treatment and experience as a patient in communications produced by or on behalf of THICCC, and consent to take and make use of my and/or my child’s audio/video/photographic images in publications produced by or on behalf of THICCC. This permission extends both to electronic versions on the THICCC websites and other internet/electronic applications, as well as to printed, filmed, and taped versions.
- I give my permission for THICCC to release my or my child’s name and details of my or his/her medical care to the news and electronic media including, but not limited to, internet/online publications, TV, radio, newspapers and/or magazines, and allow the news media to make images (digital, video, or otherwise) of me or my child for purposes of illustrating my treatment and experience as a patient of THICCC.
- I specifically authorize the release of information pertaining to alcohol, drug, and/or substance abuse, diagnosis, or treatment.
- I specifically authorize the release of information pertaining to mental health diagnosis or treatment.
- I specifically authorize the release of information pertaining to HIV/AIDS test results.

I understand that I am not required to sign this authorization. THICCC does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I can request a copy of this authorization be mailed to me. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of any information and audio/video/photographic material.

If I decide to sign this form, I have the right to request that audio/video recording, filming, or photographing cease at any time.

I am aware that my protected health information will exist forever in either a recorded, printed, and/or electronic version or other version as may develop over time, and that once it is published or disclosed in any form it will continue to be used. I understand that information about me or my child used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by HIPAA and other applicable federal and state law.

I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to the THICCC Privacy Officer at 6624 Fannin, Suite 2600, Houston, Texas 77030. I understand that THICCC, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within THICCC’s control that have not been previously published. If not revoked/withdrawn by me, this authorization expires [five (5)] years from the date that I sign it.

[Signature for this Authorization is on following page]

AUTHORIZATION

Patient Name: _____
(first) (m. initial) (last)

Signature: _____

Address: _____
(street address)

(city) (state) (zip code)

Phone: _____

Email: _____

For personal representatives, please provide the following:

I _____ represent that I am the (please select one):

- health care agent
- guardian
- surrogate
- parent of the patient above

Personal Representative Signature: _____

Date: _____

Address: _____

Phone: _____

Email: _____

***If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient.**