NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Program Description: ___________________
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APPEARANCE RELEASE AND HIPAA AUTHORIZATION
(FOR PATIENTS ONLY)

- I consent to be photographed, videotaped, recorded and/or to have information about me disclosed by The New York and Presbyterian Hospital ("NYPH"), or any person or entity authorized by NYPH, in connection with production of the program described above (such image and recording and subsequent display in any media, including printed materials, internet, video, DVD, CD or other form of distribution, is hereinafter referred to as the "Program").

- I understand that the Program may include my name, likeness, picture, image, voice, personality, personal identification information and/or "protected health information" (collectively, "my Information"). Federal privacy law defines "protected health information" as individually identifiable information which may include a patient's name, age, address, gender, race, marital and insurance status, in addition to information regarding a patient's diagnosis or medical treatment. Federal privacy law requires that I review and sign an authorization before a health care provider may use and/or disclose my protected health information for purposes other than treatment, payment or health care operations.

- I grant to NYPH and its subsidiaries, affiliates, licensees, employees, medical staff, agents, academic affiliates (*i.e.,* Columbia University and/or Cornell University), NewYork-Presbyterian Healthcare System, Inc., and to any person or entity authorized by the above (collectively, the "NYPH Group"), the right to use and disclose my Information in connection with the production, distribution, and promotion of the Program (or excerpts of the Program or derivative works made from the Program) in all media and distribution channels of any kind, whether now known or hereafter devised, worldwide, in perpetuity, including, without limitation, in NYPH Group publications, Internet websites (e.g., www.nyp.org) and intranet sites, social media sites, and any other means of distribution for educational, informational, marketing or fundraising purposes.

- I release and discharge the NYPH Group from any and all claims, demands or causes of action that I may now have or may hereafter have for libel, defamation, invasion of privacy or right of publicity, infringement of copyright or violation of any other right of mine arising out of the exercise of the rights granted herein.

- I understand that I will receive no financial compensation from NYPH for participation in the Program and I have no rights of ownership to the Program or rights to approve the Program.

- I may refuse to sign this Authorization. NYPH does not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this Authorization. My Information disclosed in reliance on this Authorization may be redisclosed and is no longer protected by any privacy laws.

- This Authorization is binding on me, my successors, assigns, heirs, executors and administrators. This Authorization expires twenty (20) years from the date hereof even if I shall be deceased prior to that time.

- This Authorization contains the entire agreement and understanding between NYPH and me regarding the subject matter hereof and no oral understandings have been made with me with regard thereto.

- I have a right to receive a copy of this Authorization and any written information disclosed based on this Authorization by contacting Public Affairs, The New York and Presbyterian Hospital, 525 East 68th Street, Box 144, New York, NY 10065.

- I may revoke this Authorization at any time by sending a written notice, signed by me or on my behalf, to the NYPH Office of Public Affairs at the address provided above. My revocation will be effective upon receipt, except to the extent that the NYPH Group has acted in reliance upon this Authorization. I understand and agree that the NYPH Group will have acted in reliance upon this Authorization upon the disclosure of my Information in accordance with this Authorization.

- This Authorization and any claim, controversy or dispute arising under or related to this Authorization, shall be governed by and construed in accordance with the laws of the State of New York, without regard to principles of conflicts of law.

- If the patient is a minor child or legally incapable of consent, I represent and warrant that I am the parent, guardian or other legal representative of the patient and that I have the legal right and power to grant the NYPH Group the rights granted herein and to release the NYPH Group on behalf of myself and the patient.

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

Patient Name (print): ____ Date: ________________________

Signature (of patient or representative*): ____

Address: ____

Email: __________________________________ Phone No.: ______________________________________

Witness Name: ____________________________ Witness Signature: ________________________________

**** Parent or other legal representative must sign if patient is under 18 years of age or legally incapable of consent***

If signed by someone other than the patient (parent, guardian or other legal representative):

Name of Representative: ________________________ Relationship to patient: ________________________

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For Internal Use: