
# Authorization for Release of Protected Health Information (PHI) for Advertising and Marketing

Name: _____ Telephone: _____

Address: _____ Email:_____

1. I authorize Eye Talk Radio and Dr. Ronald Gentile/agents and/or the following physician(s):
   Physician name(s)_____

to disclose my personal and/or medical history and/or treatment related to the following condition(s) or procedure(s):

_____

to the general public for purposes of publicizing, promoting, marketing and advertising their activities, programs and services. This use might include, but is not limited to, media in the form of one or more of the following: photograph, video, movie or audio recording. I affirm that I have previously provided verbal authorization for disclosure of this PHI to Eye Talk Radio and Dr. Ronald Gentile's personnel or agents to facilitate arrangements.

2. I understand that in the future media that I am in and the accompanying narrative may be placed in the Eye Talk Radio's Archives, where it may be used in historical displays or publications. My name would not be used In connection with any future use.

3. I understand that this authorization is valid for the duration of Eye Talk Radio's archives and that I may revoke it at any time, except to the extent that Eye Talk Radio has already taken action based on it. (To revoke this authorization, write to: Dr. Ronald Gentile, 218 Second Avenue, New York, NY 10003)

4. By Signing this form, I authorize the use or disclosure of the Protected Health Information as described above. This information may be re-disclosed if the recipient(s) described on this form is/are not required to protect the privacy of the information, and such information is no longer protected by federal health privacy regulations.

° Initial if you are authorizing release of HIV-related information, you should be aware that the recipient(s) is/are prohibited from re-disclosing any HIV-related information without your authorization unless permitted to do so under federal or state law:_____ ° If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at 212-870-8624 or New York City Commission of Human Rights at 212-566-5493. These agencies are responsible for protecting your rights.

**I understand that I am not required to sign this authorization and that my health care, payment for health care and health care benefits will not be affected if I do not sign this form.**

**SIGNATURE**:_____ Date: _____
(Participant, Personal Representative or Legal Guardian)

Personal Representative or Legal Guardian: (Print Name) _____

Authority:_____ Telephone: _____

Address_____

Witness: (Print Name):_____ Witness's Signature:_____