Beth Israel Deaconess Medical Center

Media ID Number

#_____

Authorization to Use Images, Letters, and Related Information for Internal and External Communications

As described in detail below, I authorize Beth Israel Deaconess Medical Center, including any of its employees, affiliates, or agents to photograph me, use my words, and/or to record me (video or audio), and I authorize the release of my protected health information as part of such efforts.

I understand that the information I authorize BIDMC to disclose may be re-disclosed by another individual or organization. I further authorize BIDMC to disclose my protected health information to outside organizations, including but not limited to media outlets. I acknowledge this authorization is voluntary. I understand that treatment will not be conditioned on the completion of this authorization. I know that I have the right to request and receive a Beth Israel Deaconess Medical Center Notice of Privacy Practices.

Description of Disclosure:

This disclosure applies to description of my protected health information, MRI images, photograph images, as well as video and audio recording of me for the purpose of scientific publication.

The information above may be used and disclosed in any form of communication and maintained in archives for future use. I understand that I will not receive or be entitled to any compensation related to the use and disclosure of this information. I hereby waive any right or interest I might otherwise have in regard to the use and disclosure of this information, and assign all rights I may have to Beth Israel Deaconess Medical Center and to organizations I authorize as described above. I also understand that **I may withdraw my authorization, for materials related to BIDMC only, at any time by submitting a written request to Beth Israel Deaconess Medical Center's Communications Department.**

This Authorization lasts indefinitely unless otherwise specified.

Limitations of use (if any): ___None_____

Patient Name: ___Patricia Ponticelli_____ **Address:** ___60 Highland Street_____

Telephone: _978-388-9190_____ ___Amesbury, MA 01913_____

Email: _____ _____

Signature of patient or guardian (if a minor): Patricia Ponticelli **Date:** 4-6-17