BRAVERMAN REPRODUCTIVE IMMUNOLOGY

HIPAA Privacy Policy

Use or Disclosure of Protected Health Information in Media Relations

Statement of Policy

Braverman Reproductive Immunology (hereafter "BRI") and Dr. Jeffrey Braverman are committed to conducting media relations in compliance with all applicable laws, regulation and BRI policies to protect the privacy of Protected Health Information ("PHI"). To strengthen this commitment, BRI has adopted this Policy to ensure that BRI, Dr. Jeffrey Braverman or any of its employees who engage in media relations does so in compliance with the HIPAA Privacy Regulations.

Scope of Policy

This Policy applies to all Uses or Disclosures of PHI in media relations, publicity, promotion and advertising.

Policy

1. **Media Requests for Patient Interviews, Photographs, Videotapes or Other Images.**

    a) BRI, its physicians or other employees, who have been contacted by the media to provide PHI about Individuals to be included in print, broadcast or electronic media, must obtain the Individual's written Media Authorization prior to Disclosing PHI. The Media Authorization Form is attached. This Authorization must be obtained regardless of whether the media representative is preparing an article or story for distribution for print, broadcast, electronic media or any other medium.

    b) BRI must also obtain an Individual's Media Authorization before photographing or videotaping an Individual for medical education, staff education, and promotion or publicity purposes.

Media Authorization for the Use and Disclosure of Protected Health Information

BRI makes every effort to protect your privacy rights when it comes to your Protected Health Information (PHI). If you have any questions or concerns, please speak to our office manager.

I authorize the use and/or disclosure of my protected health information as described below:

1. I authorize BRI to disclose to media representatives and/or public affairs staff members protected health information and information about me, my condition or treatment for purposes of publicity, promotion, education or publication in print, broadcast and electronic media. This authorization includes my likeness on photo, videotape and digital media. My authorization applies to the information described below. Only this protected health information may be used and/or disclosed pursuant to this authorization:

   _____

   _____

   _____

2. This authorization will expire ____ years from the date I sign this authorization.

3. I understand that once my protected health information is used and/or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s).

4. I understand that I have the right to revoke this authorization at any time. My revocation must be in writing as described in the Notice of Privacy Practices. I am aware that my revocation is not effective to the extent that I have authorized the use and/or disclosure of my protected health information and such use and/or disclosure have been relied upon by authorized recipients.

5. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from BRI nor will it affect my eligibility for benefits.

6. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the Notice of Privacy Practices.

7. I agree that I will receive no financial remuneration for the use of my image or protected health information as described herein.

_____	_____
Signature of Patient or Legal Representative	Date
_____	_____
Printed Name of Legal Representative (if applicable)	Relationship to Patient (Parent, Guardian, or Patient Representative)
_____	_____
Signature of Witness or Interpreter	Date
_____	_____
Signature of Person Obtaining Authorization	Date

MR #

NAME:

DOB:

**CONSENT FOR AND AUTHORIZATION
FOR RELEASE OF PHOTOGRAPHS, FILMS,
MEDICAL IMAGES AND OTHER MULTIMEDIA
FOR EDUCATIONAL AND PROMOTIONAL PURPOSES.**

I specifically acknowledge that the information used or disclosed may include the following types of sensitive medical information:

☐ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment.

☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment.

☐ I specifically authorize the release of HIV/AIDS test results.

☐ I specifically authorize the release of genetic testing information.

I agree that BRI will own any and all rights in the multimedia items listed above. I waive any and all rights that I may have in the use of my likeness, photograph, voice or appearance in these multimedia items. BRI will have the right to reproduce, distribute, sell, transmit, publish, exhibit, or otherwise use the multimedia items listed above. I will not receive any payment for any use of them.

I have read this paper about the use of multimedia items that contain my health information. I understand the consequences of granting permissions related to my PHI. My questions have been answered to my satisfaction, and I agree with the content of this form. I acknowledge that I have received a copy of this form.

_____	_____
Signature of Patient or Legal Representative	Date
_____	_____
Printed Name of Legal Representative (if applicable)	Relationship to Patient (Parent, Guardian, or Patient Representative)
_____	_____
Signature of Witness or Interpreter	Date
_____	_____
Signature of Person Obtaining Authorization	Date

Braverman Reproductive Immunology

MR #

NAME:

DOB:

CONSENT FOR AND AUTHORIZATION FOR RELEASE OF PHOTOGRAPHS, FILMS, MEDICAL IMAGES, ELECTRONIC MEDIA, VIDEO AND OTHER MULTIMEDIA SOURCES FOR EDUCATIONAL AND PROMOTIONAL PURPOSES.

Purpose: We ask your permission to take photographs, record films, create electronic media and/or create other multimedia content that contain your Private Health Information (PHI). The multimedia content will be created during the course of your healthcare treatment you may receive from Braverman Reproductive Immunology ("BRI"). We want to share this health information about you with other individuals and entities either inside or outside of BRI for educational and promotional purposes, so that other health sciences professionals and patients can learn about your condition. Ultimately, we anticipate that releasing your PHI and experiences of treatment at Braverman will benefit other patients.

Confidentiality: You will not be identified by your name, unless you specifically request identification. Other people may recognize your face or voice or other information that is unique to you.

> Notice: BRI, its doctors, nurses and other health professionals are required by law to keep your health information confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights: You have the right to rescind your authorization for photography or filming at any time. Your permission to BRI is voluntary. You may refuse to give permission without any penalty or loss of treatment, care or services. Your treatment, payment, enrollment and eligibility for benefits do not depend on your signing this consent form. If you have any questions about your rights, contact the Braverman Reproductive Immunology Privacy Management Office, 139 East 23 Street (Corner of Lexington Ave), Second Floor, New York, NY 10010, (855) 786-7775.

Expiration: Unless you revoke your permission earlier, this Authorization expires on _____. If no date is indicated, this Authorization will expire in five years after the date of your signing this form.

Initials of patient or personal representative: _____

MR #

NAME:

DOB:

CONSENT FOR AND AUTHORIZATION FOR RELEASE OF PHOTOGRAPHS, VIDEO, FILMS, MEDICAL IMAGES, ELECTRONIC MEDIA AND OTHER MULTIMEDIA FOR EDUCATIONAL AND PROMOTIONAL PURPOSES

I give permission for these multimedia and electronic media items to be taken, made or used:

- € Photographs:_____
- € Videos/films:_____
- € Audiotapes/audio clips:_____
- € Radiographs and other medical images:_____
- € Other multimedia items: _____
- € Electronic Media: _____
- € Health information regarding my medical condition or treatment to be released. (Please specify the health information you authorize for release):
    - Type(s) of health information: _____
    - Date(s) of Treatment: _____

I give permission to BRI to use these multimedia and electronic media items for these promotional and educational purpose(s):

- Training of health science professionals at BRI (for example in classroom lectures, faculty presentations, laboratory manuals etc.)
- Sharing with (dissemination to) other health sciences center for use in their educational programs.
- Use in professional publications and presentations, textbooks and at professional conferences.
- Use in promotional lectures, television and radio appearances, webinars, web broadcasts, websites and other available electronic media technology.

Revoking Your Permission: You may change your mind and withdraw your permission for use of the photographs, films or other materials at any time, without any penalty or loss of care or services. To revoke your permission, please send a letter to the Braverman Reproductive Immunology Privacy Management Office, 139 East 23 Street (Corner of Lexington Ave), Second Floor, New York, NY 10010, (855) 786-7775. The revocation letter will take effect when BRI receives it, except to the extent that BRI or others have already relied on it. If the multimedia items have already been shared, it may not be possible to recall them.

Initials of patient or personal representative: _____