



**AUTHORIZATION FOR  
USE AND DISCLOSURE OF PATIENT INFORMATION  
FOR EXTERNAL COMMUNICATIONS**

**Patient Name:** \_\_\_\_\_

*We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.*

*A representative from the Department of External Affairs of Hospital for Special Surgery (“HSS”) must fully answer any questions you may have regarding this form. DO NOT SIGN A BLANK FORM. You or your personal representative should carefully read the descriptions below before signing this form.*

**SIGNATURE**

*I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and that I accept all of the terms below.*

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative’s Authority

\_\_\_\_\_  
Print Name of Personal Representative

**CONTACT INFORMATION**

**The contact information of the patient or personal representative who signed this form should be filled in below.**

Address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone:  
\_\_\_\_\_ (daytime)  
\_\_\_\_\_ (evening)

Email Address (optional):  
\_\_\_\_\_

**USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION**

Health information about you that is used for HSS’s external communications will be obtained from you, HSS, and your HSS physician(s) named below. Your health information will be used by HSS and your HSS physician(s), and/or disclosed by HSS and your HSS physician(s) to the general public and/or the media, for HSS’s external communications.

I agree to permit HSS and HSS physicians to use and disclose the following health information for HSS external communications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name(s) of Your HSS Physician(s): \_\_\_\_\_

**PLEASE TURN OVER FOR MORE INFORMATION ON THE TERMS OF,  
AND YOUR RIGHTS REGARDING, THIS AUTHORIZATION**

**When will this authorization expire?** This authorization expires 10 years from the date it is signed. After the expiration of this authorization, HSS will not use or disclose your health information for external communications purposes as specified herein unless you or your personal representative authorizes such additional use or disclosure by signing another authorization form.

After your health information is disclosed by HSS for external communications purposes, your health information may be used and disclosed by other people, entities, and media who are not connected to HSS. For example, HSS cannot limit the amount of time the media may use footage or photographs for future print publications and broadcast, and HSS does not have any control over the media's use or distribution of such materials.

**Can I revoke this authorization?** You can revoke this authorization at any time before we have relied upon it. If you revoke this authorization after we have completed the external communications project, however, we may continue to use and disclose your story throughout the life of that project. If you decide to revoke your authorization, please write to the HSS External Affairs Department, 535 East 70th Street, New York, NY 10021 as soon as you make that decision.

### **SPECIFIC UNDERSTANDINGS**

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

You also have a right to receive a copy of this form after you have signed it.

***THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.***