

HIPAA SUPPLEMENTED MODEL RELEASE

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GENERAL PUBLIC FOR PATIENTS AND VISITORS**

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give permission for my remarks, photograph, and/or video recording to be taken by
SUNY Downstate Medical Center (and/or its agents) for the purposes of publicizing,
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programs, or services.

I understand that I may be identified by name in connection with the public use of the
information and material(s).

I understand that my statement, photograph, and/or video recording may be published on
SUNY Downstate's website and/or digital monitors.

I understand that neither I nor SUNY Downstate will receive any direct or indirect
remuneration as a result of this authorization.

I am a patient of SUNY Downstate Medical Center and have signed a Marketing
Communications Authorization for release of protected health information (PHI).

I am a visitor at SUNY Downstate Medical Center.

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Date _____

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