AUTHORIZATION TO USE PROTECTED HEALTH INFORMATION FOR EDUCATION AND INSTRUCTION

Individual's Name: _____
Last First Middle

Individual's Date of Birth:_____

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations:

USC[1] is committed to protecting the privacy of your health information. A federal law known as the Health Insurance Portability and Accountability Act (HIPAA) gives you protections regarding the use and release of your health information, in addition to those protections that exist under California's privacy laws. These federal and state laws require that we give you this authorization form for your review and signature.

Authorization to Use Health Information:

This authorization permits USC and your attending health care provider(s) or other persons to use your health information while undergoing treatment at USC for educational and instructional purposes as described below. These photographs or videotapes may include still images, motion recordings, prints, negatives and/or any other visual and audio recordings, or reproductions therefrom, in any format (collectively, the "Footage"). Specifically, your information will be used as follows:

_____

You understand that your picture or other details that would disclose your identity may be revealed. This authorization also permits USC and your health care provider(s) to release certain health care information relating to your treatment, which will be used for the educational and instructional purposes described above.

You grant USC the unconditional and unrestricted right to interview you and to use your name, voice, likeness, biographical information, and any or all of the Footage, either in its original form or edited by USC at its sole discretion, for educational and instructional purposes. USC is and shall be the sole and exclusive owner and holder of all intellectual property rights, title and interest to any and all the Footage, including copyrights. To the extent your participation in the Footage gives you any claim to copyrights, your involvement herein is

[1] For purposes of the HIPAA Privacy Rule, USC includes those entities that comprise Keck Medicine of USC, including but not limited to, USC Norris Cancer Hospital, Keck Hospital of USC, USC's employed physicians, nurses and other clinical personnel, those units of USC that provide clinical services within the Keck School of Medicine, School of Pharmacy, the Herman Ostrow School of Dentistry, Physical and Occupational Therapy, Suzanne Dworak-Peck School of Social Work, as well as USC Care Medical Group, affiliated medical foundations of Keck and their physicians, nurses and clinical personnel, Engemann Student Health Center, Eric Cohen Student Health Center, USC Verdugo Hills Hospital, its nurses and other clinical personnel, Verdugo Radiology Medical Group, Verdugo Hills Anesthesia, and Chandnish K. Ahluwalia, M.D., Inc. and those units that support clinical and clinical research functions, including the Offices of the General Counsel, Audit and Compliance.

deemed to be as a specially commissioned work and therefore a work made for hire.

By signing this authorization, you waive any right to compensation for such uses, and you and your successors or assigns also release and hold harmless USC, its administrators, directors, officers, employees, agents or affiliates from and against any claim for any injury in connection with the use, or display of your image, voice, likeness, or any other identifying characteristics in the presentation and use of your photograph and/or videotape, and any compensation resulting from the activities authorized by you in this authorization.

How long will this authorization be in effect?
This authorization will remain in effect for a period of _____ years from the date of your signature below.

What if I don't want to sign, or later change my mind?
Signing this form is entirely voluntary. If you don't sign, this will not affect the commencement, continuation or quality of USC's treatment of you, or your eligibility for benefits. If you have questions about how your photographs or video might be used, or if you change your mind, you can revoke this authorization at any time by providing a written notice of revocation to the address below. It will be effective upon receipt. Please note, however, that USC may continue to use and disclose any photographs and videotapes that were obtained in reliance of this authorization before receipt of a revocation.

_____
_____
_____
_____

Are the individuals who receive my health information pursuant to this authorization permitted to use or disclose it for other purposes?
USC will not use or disclose your health information pursuant to this authorization for other purposes except with your written authorization or as specifically required or permitted by law. However, you understand that you are consenting to be photographed or videotaped and authorizing the disclosure of any health information that will be contained on the photograph/videotape and discussed during its presentation for educational and academic purposes. Once disclosed, federal and state privacy protections will not apply.

Questions? If you have questions about your privacy rights, the address of USC's Office of Compliance is 3500 Figueroa, Suite 105, Los Angeles, CA 90089-8007, and you may contact the Office of Compliance by telephone at 213-704-8258 or by email at **complian@usc.edu**.

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about USC's use of my health information for possible educational or instructional purposes. I hereby knowingly and voluntarily authorize USC to use my health information for the purposes stated herein.

_____ _____

Signature of Individual/Patient Date

If Individual/Patient is unable to sign this Authorization, please complete the information below:

_____ _____ _____

Name of Legal Guardian/ Personal Representative | Legal Relationship | Date

You will be provided with a signed copy of this authorization.