THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

I, ______________________________, give The Ohio State University Wexner Medical Center permission to release Protected Health Information (PHI) about me as described below.

1. Specified information about me based on the boxes checked:
   - ☐ My name, age, city I live in, sex, and other private information, (demographics).
   - ☐ Treatment information such as my diagnosis, prognosis, hospital admission, discharge, treated/released status, etc.
   - ☐ Photographs, video or audio
   - ☐ Other (please specify): ______________________________
2. OSUWMC may release my information as specified (check all boxes that apply):
   - ☐ Publication or broadcast by hospital and/or news media channels
   - ☐ Educational purposes (professional conferences, case studies, etc.)
   - ☐ Hospital events, presentations, projects, website and/or all hospital-produced publications
   - ☐ Advertising (TV, radio, print, online, social media, etc.)
   - ☐ Other (please specify): ______________________________
3. The purpose of the release of the information is (check all applicable boxes):
   - ☐ In response to news media inquiry
   - ☐ At the request of OSUWMC
   - ☐ Disclosed at request of patient/guardian
   - ☐ Other (please specify): ______________________________
4. I understand that information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.
5. I understand that I may stop any further release of my information, at any time, by writing to Public Affairs and Media Relations or the Privacy Office at the addresses below. My request will not apply to information that has already been released, printed, recorded and/or electronically posted. This authorization expires only upon written notice from me to Public Affairs and Media Relations or the Privacy Office.
6. If applicable, I waive both ownership interest to any materials developed and authority to inspect or approve the finished materials prior to their release or publication.
7. I also understand that I am not required to sign this form and that OSUWMC will not condition the provision of treatment to me if I choose to not release my information.

______________________________ Signature of Patient (or patient representative)

______________________________ Relationship of Representative to Patient (parent, guardian, etc.)

__________ Date

Date of Birth: ______________________________
Mailing Address: ______________________________
Daytime Phone: ______________________________
Email Address: ______________________________

For Photo/Media Releases Return Signed Form to:
The Ohio State University Wexner Medical Center
Public Affairs & Media Relations
650 Ackerman Rd., Suite 135
Columbus, Ohio 43202
Phone: 614-293-3737 or mediarelations@osumc.edu

For All Other Releases Return Signed Form to:
The Ohio State University Wexner Medical Center
Privacy Office
600 Ackerman Road, E2175
Columbus, Ohio 43202
Phone: 614-293-4477 or privacyoffice@osumc.edu

Offer a Copy of this Signed Form to the Patient/Legal Guardian ☐ Copy provided ☐ Offer of copy declined

Patient Name:

Medical Record Number:

Date of Birth:

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RELEASE OF PATIENT INFORMATION FOR MEDIA, EDUCATIONAL PURPOSES, OR CASE STUDIES