THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

I, _____, give The Ohio State University Wexner Medical Center and its affiliate, Ohio State University Physicians, Inc., 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. The Ohio State Wexner Medical Center 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 the Wexner Medical Center
   - ❑ 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 the Wexner Medical Center 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 and Media Relations
650 Ackerman Road, 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
1590 N. High Street, Suite 500
Columbus, Ohio 43201
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

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CHECK ONE (REQUIRED):
- ❑ **THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER**
- ❑ **ARTHUR G. JAMES CANCER HOSPITAL & RICHARD J. SOLOVE RESEARCH INSTITUTE**
- ❑ **WEXNER MEDICAL CENTER AMBULATORY SURGERY CENTER**

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

Patient Name:

Medical Record Number:

Date of Birth: