

Williamson County EMS
Authorization to Release Protected Health Information



I, _____ (name of patient), do hereby authorize Williamson County EMS to use and/or disclose health information about me, as specified below, to:

- Reporters for local, state and national media outlets, including newspapers, magazines, television broadcast stations, radio stations, internet, and social media sites.
- Williamson County Public Information department or anyone authorized by Williamson County for marketing and promotional purposes.

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information:

- ___ All photography, video, audio, and/or printed testimonial taken from me
- ___ Information about my specific injuries or medical condition or diagnosis
- ___ My prognosis
- ___ My age
- ___ My city, county, and/ or state of residence
- ___ The date and time of my expected or actual discharge from the hospital
- ___ Information disclosed during or necessary to conduct an interview with me at a hospital or other agreed upon location

I understand any and all reproductions of materials including my image, voice, condition (as outlined above) or personal testimony obtained on the date of this release remains the property, solely and completely, of Williamson County EMS, to be used exclusively for the promotion of Williamson County without further compensation to me.

I hereby release and discharge Williamson County, Williamson County EMS, and its officers, employees, and agents from any and all claims and demands arising out of or in connection with the use of the above information pursuant to this Authorization, including any and all claims for libel or invasion of privacy.

I understand that by signing below I am voiding any previous elections to "opt out" of releasing my health information, but only for the express purpose(s) outlined above.

I understand that media representatives are not covered by federal privacy regulations and my health information may be disclosed and no longer protected by these regulations.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

Finally, I do understand that I may revoke this authorization at any time, provided that I do so in writing. I understand that information released between the effective date of this authorization and the date of the revocation may still be used in the public domain. I have read the foregoing and fully understand the contents thereof.

Print Patient(s) Name Date

Signature of Patient or Patient's Representative (Parent/POA)

Print Name of Personal Representative (if applicable) Relationship to Patient

Witness Printed Name & Signature Date