HPF2.05a
Media Release

We understand that information about you or your child is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we need your permission before we disclose your or your child's protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

Use And Disclosure Covered By This Authorization

I, _____authorize _____(insert Network Agency name) to take and disseminate photographs, videos and/or interviews of myself or of my child and to release such information for use in any YAI Network newsletters, annual reports, marketing or training materials, displays, appeals, media, and YAI Network and Central Park Challenge websites and social media sites. I understand that these materials and identifying information will be used to promote public understanding and support of programs for people with developmental and/or learning disabilities.

By signing this form, I authorize the use or disclosure of my protected health information in connection with the above-referenced uses. I understand that this information may be redisclosed if the recipient(s) is not required by law to protect the privacy of the information and/or if such information is no longer protected by federal health information privacy regulations.

I understand that YAI may receive indirect compensation as a result of fundraising involving the use of the above referenced materials. I further consent and waive any right I may have under the New York State Civil Rights Law, Section 50, in relation to the use of my name, portrait, picture or information in advertising or marketing.

I understand that this authorization expires three years after execution of the authorization.

I also understand that I have a right to refuse to sign this authorization and that my health care services, the payment for my health care services and my health care benefits will not be affected if I do not sign this form.

I understand that I have a right to receive a copy of this form after I have signed it.

I further understand that I have the right to revoke this authorization at any time, except to the extent that YAI has already taken action in reliance upon my authorization. To revoke this authorization, I must write to Lynn Berman at YAI at 460 West 34th Street, 11th Floor, New York, N.Y. 10001.

I have read this form and all of my questions about this form have been answered.

By signing below, I acknowledge that I have read and that I accept all of the above.

Print name of Individual in Photograph

Signature of Individual or Guardian

Print name of Individual or Guardian

Date

Program Name

Address of Individual or Guardian

City	State	Zip code

Phone (h)	(w)	cell

E-mail Address