NEUROSURGICAL ASSOCIATES
HIPAA MEDIA AUTHORIZATION

- I have been asked to participate in the production of a health media initiative (the "program") which will be produced and distributed by any and all media (the "Producers");
- Neurosurgical Associates ("N.A.") has permitted the Producers to film/video and/or write and/or photograph one or more segments of the Program; and
- As part of my participation in the production of one or more segments of the Program it will be necessary for the Producers and/or N.A. to use, simulate and portray my name, voice, likeness, picture, image, personality, personal identification information and personal "individually identifiable health information" (see below) (collectively, "Name and Health Information") in connection with the production, distribution, promotion, advertising and exploitation of the Program.
- Federal privacy law requires that I review and sign an authorization before N.A. may use and/or disclose my patient health information for the above described purposes.
- By reviewing and signing this Authorization, I grant to N.A., and to any persons or entities authorized by N.A. ("N.A. Group"), the right to use, simulate and portray my Name and Health Information in connection with the production, distribution, promotion, advertising and exploitation of one or more segments of the Program in all media and distribution channels of any kind, whether now known or hereafter devised.
- Release and discharge the N.A. Group from any and all claims, demands or causes of action that I may now have or may hereafter have for libel, defamation, invasion of privacy or right of publicity, infringement of copyright or violation of any other right of mine arising out of or relating to any such use of my Name and Information in connection with the production, distribution, promotion, advertising and exploitation of one or more segments of the Program; and
- I agree that this HIPAA Authorization contains the entire agreement and understanding between N.A. and me regarding this subject.
- TREATMENT WILL NOT BE CONDITIONED ON MY SIGNING OR REFUSING TO SIGN THIS AUTHORIZATION. I MAY REFUSE TO SIGN THIS AUTHORIZATION. IF I REFUSE TO SIGN THIS AUTHORIZATION, I MAY NOT BE PERMITTED TO PARTICIPATE IN ANY ASPECT OF THE PRODUCTION OF THE PROGRAM.
- This Authorization does not expire. I have a right to receive a copy of this Authorization.
- I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and sent or delivered to the following address: Attn: Department of Marketing and Media—Neurological Institute, Columbia University Medical Center, 710 West 168th Street, 4th Floor, New York, NY 10032. My revocation will be effective upon receipt.

Date: _____

Name: _____
(Please print)

Address: _____

Phone: _____

Signature: _____
Patient/Legal Representative/
Legal relationship to the patient, if signed by someone other than the patient

: _____

WITNESS: _____