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CONNECT

HIPAA AUTHORIZATION FORM

To Use / Disclose Patient Health Information for Media, Promotional, and Publication Activities

PATIENT INFORMATION

I hereby authorize Baylor Genetics to use and/or disclose the name, images and other protected health information (PHI) of the following individual:

Last Name	First Name	MI	Date of Birth (MM / DD / YYYY)
			____ / ____ / ____

INFORMATION TYPE

Any health-related information regarding the above-named person, including, but not limited to, health information, personal information, testimonial, photographs, or other images, except: _____.

Your initials are required to authorize release of genetic information: _____

INFORMATION OVERVIEW

Information to Be Released to:

◯ Baylor Genetics ◯ Other _____

For the Purpose of:

- Baylor Genetics publications/promotional materials, including print and online
- Baylor Genetics website, social media and other interactive and educational communications
- Community Outreach or Advocacy
- News Media
- Other (Describe): _____

I give authorization in the interest of public information, furtherance of patient care and educational goals of Baylor Genetics, or for other lawful purposes. I authorize Baylor Genetics to disclose information as described above to the public through any form of media (e.g., Baylor Genetics publication, newspaper, TV, magazine, internet, social media platforms such as Facebook, X, LinkedIn, Instagram, film, etc.).

Effective Time Period: This authorization is effective until revoked in writing by the patient or their Legal Representative or until this date, _____, whichever occurs earlier.

ACKNOWLEDGEMENT

By signing below, I understand and agree to the following:

- Baylor Genetics will not receive any payment or other form of remuneration for use or disclosure of the health information.
- No payment or other form of remuneration will be received for providing authorization to use or disclose any health information and or audio/video/photographic material.
- The health information of the above-named person used or disclosed under this authorization will exist forever in either a recorded, printed, and/or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used. It may also be subject to redisclosure and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 and other applicable federal and state law.
- This authorization can be revoked at any time by sending a written revocation to compliance@baylorgenetics.com. I understand the revocation will not apply to any health information previously disclosed in reliance of this authorization.
- Any treatment, payment or my enrollment in any health plan, or my eligibility for benefits will not be affected if I chose to not sign this Authorization.
- I am entitled to receive a copy of this signed Authorization.

Signature of Patient or Personal Representative*	Date Signed (MM / DD / YYYY)
	____ / ____ / ____

Printed Name of Patient or Personal Representative*

05.26.26