Westchester Jewish Community Services

PHOTO/VIDEO/PRINT INTERVIEW MEDIA RELEASE

(Authorization for Disclosure of Protected Health and/or Other Client Information)

Date:_____

Name_____ Date of Birth_____

I hereby authorize **Westchester Jewish Community Services (WJCS)** to disclose and/or publish specific information consisting of: Photographs, videos, written materials or oral statements, artwork or poetry that may be quoted or reproduced in agency or local area newsletters, magazines, newspapers or publications.

This information can be disclosed to: Media sources including but not exclusive to print, videotape or broadcast (TV, cable TV, radio), and to WJCS publications such as newsletters, annual reports, agency videos, and WJCS social media channels and website.

For the specific purpose of: General publicity, public education and fundraising.

This authorization will be active for ten years from the date of this release.

The person requesting the authorization WILL NOT receive compensation in exchange for using or disclosing health information.

I understand that I may be quoted and any of the above may be reproduced and published in agency or local area newsletters, magazines, newspapers, website and/or external publication (radio, television, video, web broadcast or Internet/social media).

I understand that if the organization authorized to receive the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

I understand that my authorization is voluntary and I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing, at any time except to the extent that we have already used or disclosed the information on this authorization. To revoke this authorization, I understand I will need to write to our Privacy Officer, Rachel Scherer, at 845 North Broadway, White Plains, NY 10603.

Signature of client or
client's representative _____ Date _____

Printed name of client's representative _____

Relationship to the client _____

Witnessed by _____

If applicable, Event_____ Event Location_____

A copy of this signed form must be provided to the client.