Washington University in St. Louis

Exhibit A

Media Authorization for the Use and Disclosure of Protected Health Information

This form is a part of our effort to protect your rights.
If you have any questions or concerns, please talk to the person helping you with the form.

I authorize the use and/or disclosure of my protected health information as described below:

1. I authorize Washington University to disclose to media representatives and/or public affairs staff members protected health information and information about me, my condition or treatment for purposes of publicity, promotion, education or publication in print, broadcast and electronic media. This authorization includes my likeness on photo, videotape and digital media. My authorization applies to the information described below. Only this protected health information may be used and/or disclosed pursuant to this authorization:
   _____
   _____
2. This authorization expires 10 years from the date that I sign this authorization.
3. I understand that once my protected health information is used and/or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient(s).
4. I understand that I have the right to revoke this authorization at any time. My revocation must be in writing as described in the Notice of Privacy Practices and sent to HIPAA Privacy Office, Washington University, 660 S. Euclid Ave., Campus Box 8098, St. Louis, MO 63110. I am aware that my revocation is not effective to the extent that I have authorized the use and/or disclosure of my protected health information and such use and/or disclosure has been relied upon by authorized recipients.
5. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Washington University nor will it affect my eligibility for benefits.
6. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the Notice of Privacy Practices.
7. I agree that I will receive no financial remuneration for the use of my image or protected health information as described herein.
8. I certify that I have received a copy of this authorization.

_____
Name of Individual

_____
Signature of Individual, Parent or Personal Representative (Parent or legal guardian must sign for anyone under 18 years of age) — Date

_____
Name of Personal Representative

_____
Relationship of Personal Representative to Individual — Physician Name (if applicable)

_____
Individual's Address — Subject

_____
Individual's Phone — Purpose

_____
Individual's E-mail Address

_____
Signature and Name of Washington University Employee (Witness) — Date