



# Authorization to Use/Disclose Protected Health Information for Media Purposes

## What is the Purpose of this Authorization?

With this form, you are authorizing Walmart Inc. and its U.S. subsidiaries, including Sam's Club and Puerto Rico ("Walmart") to capture, use, and/or disclose photographs, videorecordings, and/or audiorecordings, and other identifying information protected under the Health Insurance Portability and Accountability Act (HIPAA). This Protected Health Information (PHI) may be used for media purposes internally within Walmart, disclosed to our contracted business partners who assist in our media efforts but may not be subject to HIPAA, provided to or collected directly by the media such as journalists, or disclosed externally to the public in formats including but not limited to articles, advertisements, websites, presentations, social media, etc.

## Section 1: Patient Information

Patient Name (last, first, middle initial):		Date of Birth (mm/dd/yyyy):	
Address:			
City:	State:	Zip Code:	Phone Number:

## Section 2: Event/Service Information

Date:	Store:
Event or Service:	

## Section 3: Information to be Released

By signing below, I understand that the information listed below will be used and disclosed pursuant to this Authorization. Once disclosed, it may be republished or incorporated in other works or materials (collectively "Personal Content") which may be captured, used, and/or disclosed by Walmart. I hereby perpetually and irrevocably give Walmart exclusive authority and permission to use the Personal Content in any medium and for any purpose whatsoever. I agree and understand that the Personal Content may be modified or distorted and that my own name, a fictitious name, or no name may be used in association with the Personal Content. I irrevocably release, discharge, and hold harmless Walmart from any claims, demands, or causes of action that I may now have or may hereafter have for defamation, slander, libel, invasion of privacy or right of publicity, copyright infringement, or any other right arising out of or relating to the use of the Personal Content disclosed prior to revocation of this Authorization. Information released prior to revocation of this Authorization will remain authorized for use. Any information not used prior to revocation of this Authorization will not be used upon timely delivery of the revocation.

- Name
- Age
- Treatment or health service
- City and state of residence
- City and state of treatment
- Audio recordings
- Photographic images
- Video images/recordings
- Comments, such as service reviews or ratings
- Other details that may disclose identity

## Section 4: Expiration Date of Authorization

This authorization will remain in effect for a period of six (6) years.
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## Section 5: Understandings

- I understand that signing this authorization is voluntary. Walmart will not deny Pharmacy or Vision Center/Optical services to me if I refuse to sign this authorization.
- I understand that when my information is used or disclosed for media purposes in relation to the event or service named above, it will exist forever in various formats, which may include but are not limited to recordings, prints, or electronic media. Once disclosed, it may continue to be used and/or re-disclosed and may no longer be protected by federal or state privacy laws, such as HIPAA.
- I have the right to revoke this Authorization at any time by completing a "Revocation of Authorization to Release Protected Health Information" form available in any Walmart or Sam's Club Pharmacy or Vision Center/Optical. The revocation will not apply to PHI Walmart released in accordance with this authorization prior to receiving the revocation. I understand Walmart may retain copies of the information, and that my revocation only applies to information in Walmart's control that has not already been disclosed or published at the time Walmart received the revocation.

**Section 6: Signature and Date**

\_\_\_\_\_  
Name of Patient or Personal Representative (please print)      Signature of Patient or Personal Representative      Date

If you have signed this form as a legally authorized representative of the patient, please identify your relationship to the patient (parent, guardian, power of attorney, etc.).

\_\_\_\_\_

**For Store/Club Use Only**

Store/Club Number: \_\_\_\_\_  
Send completed form to HIPAA Privacy at directed in POM/VCOG 1610.