ACA/NY
ADVANCE CARE ALLIANCE

Advance Care Alliance of New York
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Consent and Authorization to be Photographed and Recorded

Name: _____ Address: _____

TABS: _____ Phone: _____

Email Address:_____

Please review and check boxes below:

PHOTO/VIDEO

Yes ☐ No ☐ I hereby voluntarily agree to have my photo and/or video taken by Advance Care Alliance of New York, Inc. (ACA/NY), a NYS designated Care Coordination Organization/Health Home.

Yes ☐ No ☐ I hereby authorize ACA/NY to use my photograph and/or video recording in its newsletters, brochures, social media and/or on its website.

INTERVIEW

Yes ☐ No ☐ I hereby voluntarily agree to be interviewed by Advance Care Alliance of New York Inc. (ACA/NY), a NYS designated Care Coordination Organization/Health Home.

Yes ☐ No ☐ I hereby authorize ACA/NY to include my comments from the interview in its newsletter, brochures, and/or on its website. I understand that ACA/NY will only use my first name. I further understand that to the extent that I have provided information about my health, treatment or my healthcare providers, such information may also be included in ACA/NY newsletters, brochures and/or on the ACA/NY website.

REVOKE/REFUSE

Yes ☐ No ☐ I understand that I may revoke this authorization by notifying ACA/NY at incidentmanagement@myacany.org. If I revoke my authorization ACA/NY will remove from its newsletters, brochures, social media and/or on its website, my photograph and any article that contains identifying information about me. I understand that any published information may have been re-published by a recipient of the information which is beyond the control of ACA/NY.

Yes ☐ No ☐ I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits.

Signature of Individual or Family Member/Advocate: _____ Date:_____

Name of Family Member/Advocate (if applicable):_____