HEALTH
UNIVERSITY OF UTAH

PATIENT AUTHORIZATION FOR RELEASE OF AND ACCESS TO PHOTOGRAPH, VIDEO RECORDING, FILM, AND/OR INTERVIEW

Patient Name: _____ Medical Record #_____

Date of Birth _____ Phone #_____

Patient Address:_____ City:_____ State:_____ Zip:_____

1. **I authorize University of Utah Health (U of U Health) to collect my information in the following way(s). I understand that this is voluntary and that I am not required to sign this authorization.**

   I am authorizing the following: (Check **all** that apply.)

- ☐ Photograph
- ☐ Film/Video recording
- ☐ Interview
- ☐ Voice Recording
- ☐ Other (be specific) _____

2. **I authorize U of U Health to disclose this protected health information in the following ways(s):** (Check **all** that apply.)

- ☐ To provide medical education or training to organizations outside U of U Health
- ☐ For publication in newspaper(s), magazine(s), in electronic media such as websites, or in other publications
- ☐ To provide updates on the progress of my care to the media, community, or other organization(s)
- ☐ In a broadcast by radio, television, or webcast
- ☐ In a posting online or on an internal U of U Health webpage
- ☐ In a posting on an external internet page or on social media
- ☐ To speak to the media or other third party not affiliated with U of U Health
- ☐ For Telemedicine recording
  NOTE: By checking this box you authorize U of U Health to temporarily store the telemedicine recording on a limited access website, where you may access the recording for your own health care needs. The recording will not be part of or otherwise stored with your medical record. Although U of U Health has employed industry-standard practices designed to ensure the confidentiality of the information, even the most secure system can be compromised and U of U Health cannot guarantee security of the recording.
- ☐ For video recording of my procedures to be used by U of U Health in broadcast(s) or on an external website for public access

U of U Health will NOT release your photograph, video, or recording outside of the organization in an *identifiable* form without your authorization, unless we are required to do so by law.

I understand that:

1. I understand that any information I provide for an online posting, social media, or broadcast may no longer be protected and that any information broadcast, posted, or distributed may no longer be protected. I also understand that the information may be further used or disclosed by a third party without restriction.
2. When I authorize the U of U Health to contact outside organizations, such as media outlets, U of U Health is acting only as the intermediary, making it possible for these organizations to contact me.
3. I relieve and hereby agree to hold the University of Utah harmless from any and all liability arising out of the use and/or release of information, interview, photograph, video recording, film, as well as any subsequent publication, posting online or broadcast. I understand that the interview(s), recording of treatment encounters, or photo session(s) are being carried out with my consent and authorization, and I assume full responsibility.
4. I have the right to stop the photography, filming, or recording session at any time during the session.
5. I may revoke this authorization in writing at any time by sending a written revocation of authorization form to: Medical Records, 50 North Medical Drive, SLC UT 84132. **Note**: This means that U of U Health will no longer disclose any *identifiable* photographs, videos, interviews, or other images or audio of me. U of U Health may continue to use images or audio that have been de-identified. However, I understand that U of U Health is unable to retract any photographs, video, and/or audio that have already been published or provided to a third party or accessed by a third party following broadcast or posting.
6. I understand that if any authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by these regulations, and the recipient may re-disclose the information.
7. I understand that U of U Health will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.
8. This authorization expires at the end of the useful life of the information.
9. I can contact the U of U Health Information Privacy Office at (801) 587-9241 if I have questions or concerns about how my information is being used, or to report any privacy issue.

_____ _____ Signature of Patient or Representative Date	*Description of Personal Representative Authority: ☐ Parent ☐ Medical Power of Attorney
_____ If Applicable, Name of Personal Representative*	☐ Other, explain: _____ and attach documentation.

Signature must be verified by University staff OR must be notarized. When complete, place in patient's medical record.

_____ _____ _____
Signature of University of Utah Employee Printed Name and Employee ID# Date

SUBSCRIBED AND SWORN before me this _____day of _____, 20____.

NOTARY PUBLIC
Residing in _____

My Commission expires: _____