

Place Patient Label Here

Print Patient Name

Patient MR #



UAMS Office of Communications
AUTHORIZATION FOR DISCLOSURE
of PATIENT PHOTOGRAPHS or VIDEO/AUDIO RECORDINGS or INTERVIEW/ARTICLE

I, [Print Patient Name] hereby give my permission and authorize UAMS** to make and DISCLOSE (check all that apply) Photographs Video Recordings Audio Recordings Interview/article to the public for educational, commercial, or other purposes as follows:

(PATIENT - please strike through and initial any of the disclosures you are NOT authorizing, if any).

- 1. UAMS internet website(s);
2. UAMS Posters, UAMS Publications, UAMS Photograph Books (by, on behalf of, or about UAMS);
3. Media, Internet Websites, Publications (TV, newspaper, magazine, any other media or websites outside UAMS);
4. Healthcare-Related Presentations, Seminars, Conferences and Meetings (within and outside UAMS); and
5. Other disclosures authorized, if any

Additional Health Information Disclosed. I understand and agree that any photographs/recordings/interviews/articles authorized by me may also disclose my Protected Health Information related to my treatment, condition, procedure, surgery or other Protected Health Information associated with the photographs or video/audio recordings or interview or article, and I authorize this disclosure.

Expiration Date - This Authorization expires two years from the date I sign the Authorization, or after the photographs and recordings and interviews are no longer needed by UAMS for the use and disclosure that I have authorized, whichever date is later.
Withdrawal of Authorization - I understand that I am not required to sign this Authorization. If I sign this Authorization, I may revoke/withdraw the Authorization at any time by giving written notice to UAMS Office of Communications Slot # 890, 4301 W. Markham, Little Rock, AR 72205. A withdrawal of this Authorization will not apply to records, information, photographs, audio/visual recordings or other information already used/released in reliance upon the Authorization. A photocopy or faxed copy of this signed Authorization shall constitute a valid authorization. During the recording/filming, I have the right to stop recording/ filming at any time.
Release of Liability - I agree that UAMS, including its governing Board, physicians, agents and employees, are hereby released from legal responsibility or liability for the access and release of my information to the extent indicated and authorized herein.
Re-Disclosure - I understand that once the above information is disclosed, it may no longer be protected by privacy laws.
UAMS will not condition treatment, payment, enrollment or eligibility for benefits on your signing of this Authorization.

**If patient is a patient of Arkansas Children's Hospital (ACH), the terms of this Authorization also include and extend to ACH.

Signature of Patient or Legal Representative Date

Patient Date of Birth and/or Social Security Number For Identification Purposes:

If Legal Representative has signed on behalf of Patient, state the authority of Legal Representative to do so:

(such as parent of a minor, court-appointed guardian, appointed in a Power of Attorney)

Provide Copy of Signed Authorization to Patient/Legal Representative

FOR UAMS OFFICE OF COMMUNICATIONS STAFF TO COMPLETE

Person Making Photo/Recording/Interview Date Taken (for initial photo/recording/Interview)

(check all that apply) Photographs Video Recordings Audio Recordings Interview/article

Description: