(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

UAMS Office of Communications
HIPAA AUTHORIZATION FOR DISCLOSURE of PATIENT INFORMATION

I, _____ hereby give my permission and authorize UAMS to release information about my current treatment and medical condition to:

____ **UAMS Office of Communications & Marketing** 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).

- UAMS internet website(s), Social Media;
- UAMS Posters, UAMS Publications, UAMS Photograph Books (by, on behalf of, or about UAMS);
- Healthcare-related Presentations, Seminars, Conferences and Meetings (within and outside UAMS); and
- Other disclosures authorized, if any _____.

____ **Media outlet(s)** to make and **DISCLOSE** to the public for the following educational, commercial or other purposes
(PATIENT – please strike through and initial any of the disclosures you are NOT authorizing, if any).

- Television
- Radio
- Newspaper
- Internet Websites, publications (newspaper, magazine, any other media or websites outside of UAMS);
- Other_____

Additional Health Information Disclosed. I understand and agree that any photographs/recordings/interviews 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 one (1) year 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_____Time_____

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*)

FOR UAMS OFFICE OF COMMUNICATIONS STAFF TO COMPLETE

Patient Address: _____
Street Address or P. O. Box ***City*** ***State*** ***Zip***

Patient Phone: _____ **Patient Email:** _____

Person Making Photo/Recording/Interview_____Date Taken_____ (Initial photo/recording/interview)
Description:

Staff Member Signature _____ **Date**_____ **Time**_____

Provide Copy of Signed Authorization to Patient/Legal Representative