



AUTHORIZATION TO PHOTOGRAPH, FILM, OR INTERVIEW A PATIENT

Patient Name _____ **Medical Record #** _____

Date of Birth _____ **Phone # (_____)** _____

Patient Address _____

I authorize the University of Utah Health Sciences Center (UUHSC) or news agencies to make photographs, slides, films, videotapes, or other recordings or reports of _____ that may be used in newspaper or magazine articles, television or radio broadcasts, movies or any other media or means of dissemination.

I consent to the use of my name, likeness, or voice for such purposes. I release UUHSC officers, agents, and employees from all claims of liability with respect to the showing, use, or dissemination of the material.

I understand these conditions:

1. If I am participating in a federally funded program for the treatment of substance abuse, this authorization may allow UUHSC or news agencies to disclose information regarding my participation in that program.
2. The information that news agencies receive under this authorization will no longer be protected by federal privacy regulations, and the news agencies may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
3. UUHSC 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.
4. 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. My revocation will not be effective to the extent that action has been taken in reliance on this authorization.
5. This authorization expires at the end of the useful life of the images or reports.

Signature of Patient or Representative Date

If Applicable, Name of Personal Representative*

*Description of Personal Representative Authority:

Parent Medical Power of Attorney

Other, explain: _____
and attach documentation.

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

- _____
Signature of UUHSC Staff Member Printed Name and Employee ID# Date

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

NOTARY PUBLIC
Residing in _____

My Commission expires: _____