



Photo Consent Form

AUTHORIZATION FOR RELEASE OF INFORMATION AND/OR PUBLIC USE OF IMAGE (PHOTOGRAPH OR VIDEOTAPE)

I hereby give my consent to participate in a promotional story, program, advertisement, and/or image (photograph and/or videotape) made for or about University of Iowa Health Care in which I (or the person named below, for whom I am giving consent) will be interviewed and quoted by name. I have been told that this story, program, advertisement, and/or image (photograph or videotape) may appear in the public media, including print, internet, and/or broadcast media for a period of up to six (6) years. I have been told that this story, program, advertisement, and/or image (photograph and/or videotape) may be used by UI Health Care more than once for promotional purposes.

I have been informed that once information is disclosed it may no longer be protected by federal privacy regulations. I have been informed that this authorization is voluntary and that I may revoke this authorization at any time by providing notice in writing to the following address: UI Health Care Marketing and Communications, Collegiate and Community Relations, 4144 Westlawn, Iowa City, IA 52242. The revocation will not affect any actions taken before the receipt of this written notification. Questions? 319-335-8886

TO BE COMPLETED BEFORE VISITOR OR VISITOR'S PARENT OR LEGAL GUARDIAN SIGNS THIS AUTHORIZATION: University of Iowa Health Care will not receive, directly or indirectly, financial compensation from a third party for the use and/or disclosure of the health information described above.

Visitor's Name (Please Print)

Date

Address

City

State

Zip

Home Phone

Work or Cell Phone

E-mail

Signature of Visitor or Visitor's Parent or Legal Guardian

Date

Printed name of Visitor or Visitor's Parent or Legal Guardian

Relationship to Visitor

Visitor's Birth Date