Patient? Yes ☐
No ☐

If patient, send completed form to Health Information Mgt., 2048 SRF

Patient Name _____

Hospital # _____

To be scanned and placed in the electronic medical record

Consent Form

University of Iowa Health Care

University of Iowa Hospitals and Clinics
University of Iowa Roy J. and Lucille A. Carver College of Medicine

AUTHORIZATION FOR RELEASE OF INFORMATION AND/OR PUBLIC USE OF IMAGE (PHOTOGRAPH OR VIDEOTAPE) UNIVERSITY OF IOWA HEALTH CARE MARKETING AND COMMUNICATIONS

I hereby give my consent to participate in an image (photograph and/or videotape) made for University of Iowa Health Care in which I (or the person named below, for whom I am giving consent). I understand that I will not be identified by name. I have been told that this image (photograph or videotape) will appear in the public media, including print, internet, and/or broadcast media indefinitely. I have been told that the image (photograph and/or videotape) may be used by UI Health Care more than once for educational purposes. I have been told that my health care and the payment of my health care will not be affected if I do not sign this form.

_____ _____
Patient/Subject Name (please print) **Date**

_____ _____ _____ _____
Address **City** **State** **Zip**

_____ _____ _____
Home Phone **Work Phone** **E-mail**

Intended use:

NEWS MEDIA _____

PUBLICATION TITLE _____

VIDEO TITLE _____

WEB SITE ADDRESS http:// EyeRounds.org and/or http://www.medicine.uiowa.edu/

OTHER (please specify) _____

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.

COMPLETE ABOVE BEFORE PATIENT/SUBJECT OR PATIENT/SUBJECT'S REPRESENTATIVE 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.

_____ _____
Signature of Patient/Subject or Patient/Subject's Representative **Date**

_____ _____
Printed name of Patient/Subject's Representative **Patient/Subject's Birth Date**

_____ **or** _____
Relationship to Patient/Subject **Legal Authority (attach supporting documentation)**