Hospital #: _____

PRINT

University of Iowa Health Care Authorization Form

ADMIN-AUTHORIZATION FOR RELEASE OF INFORMATION AND/OR USE OF PHOTOGRAPH, VIDEO, AND AUDIO

TO BE COMPLETED BEFORE PATIENT OR PATIENT REPRESENTATIVE SIGNS THIS AUTHORIZATION.

This completed form must be scanned into the patient's medical record in Epic.

_____ _____
Patient Name (please print) Patient Birth Date

_____ _____ _____ _____
Address City State Zip Code

_____ _____ _____
Home Phone Work or Cell Phone Email

I agree to allow the University of Iowa/UI Health Care/UI Center for Advancement to interview, photograph, video monitor, video record, and audio record me (or the patient named above for whom I give this permission) for the following purpose(s) marked below:

☐ **Promotional uses** that may include identifying information alongside my name, my image, my likeness, and/or my spoken or written comments. I understand that these promotional uses may include feature stories, advertisements, videos, or other formats that will appear in public media.

☐ **Educational or operational uses in an academic setting or publication**, including but not limited to, a professional conference or journal, or a hospital guided tour. I understand that photographs and/or audio/video recordings may be a part of my medical record. Captured photographs and/or audio/video recordings will include only the minimum and relevant content necessary to satisfy the specified and authorized purpose.

I understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that once this information is disclosed, it may no longer be protected by federal privacy regulations. I understand that this authorization is voluntary and that I may revoke this authorization at any time by providing written notice to the following address: UI Health Care Marketing and Communications, 200 Hawkins Drive, W319 GH, Iowa City, IA 52242-1009. I understand that if I revoke this authorization, it will not affect any actions taken by University of Iowa/UI Health Care/UI Center for Advancement prior to it receiving my written notification. I understand that I may call 319-356-1009 with any questions I have regarding this authorization. **This authorization is valid for an indefinite period of time or as indicated _____ (date).**

Signature of Patient or Patient Representative: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

OR Legal Authority: _____
(attach supporting documentation)

Sample photo of patient/visitor for MarCom use.

UI Health Care Use Only: Form obtained by _____ (Name) _____ (Department)

Revised: 6-2021