Hospital #: ______________

PRINT

University of Iowa Health Care Authorization Form

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

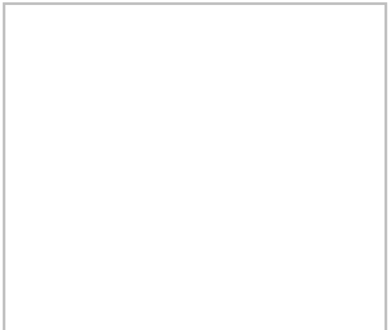
I understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that once this information is disclosed, it may no longer be protected by federal privacy regulations. I understand that this authorization is voluntary and that I may revoke 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