University of Iowa Health Care Consent Form

Print

Authorization for Release of Information and/or Public Use of Image (Photograph or Videotape)

Clear All Fields

Send copy of completed form to Health Information Management (HSSB, Suite 100) to be scanned into patient's medical record. (Non-patient forms are retained by the department acquiring consent).

MRN: _____

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

_____ _____

Patient or Visitor's Name (please print) Patient/Visitor's Birth Date

_____ _____ _____ _____

Address City State Zip Code

_____ _____ _____

Home Phone Work or Cell Phone E-mail

_____ _____

Signature of Patient/Visitor or Patient/Visitor's Representative Date

_____ _____

Printed name of Patient/Visitor's Representative Relationship to Patient/Visitor

_____

OR Legal Authority (attach supporting documentation)

_____

Today's Date

UNIVERSITY OF IOWA HEALTH CARE

Sample photo of patient/visitor for internal use.

_____

Intended Use (but not limited to)

I agree to allow UI Health Care/UI Foundation to interview, video record, and/or photograph me (or the person named above for whom I give this permission, in which case all referenced to "my" throughout this consent shall be considered as references to the person named above). I understand that UI Health Care/UI Foundation may use my name, my image, and/or my spoken or written comments for promotional uses. I understand that these promotional uses may include feature stories, advertisements, videos, or other formats that will appear in public media. I agree to allow UI Health Care/UI Foundation to use my name, comments, and/or image for up to six (6) years without additional approval. 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 UI Health Care prior to it receiving my written notification. I understand that I may call 319-356-1009 with any questions I have regarding this authorization.