**UNIVERSITY OF COLORADO DENVER | ANSCHUTZ MEDICAL CAMPUS**

**PATIENT CONSENT TO PHOTOGRAPH/VIDEOTAPE/FILM/INTERVIEW AND/OR   
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

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| --- | --- | --- | --- |
| **Patient Name:** | | **Birth Date:**  **Medical Record Number:** | |
| **Person(s) or Class of Persons Authorized to Use/Disclose the Information:**  **CU Anschutz University Communications** | | **Persons Authorized to Receive the Information:**  **N/A** | |
| **Patient consents to be:**  Photographed Filmed Videotaped Interviewed None of the forgoing  Other: | | | |
| **Purpose of Use/Disclosure:**  Publication in newspaper(s), magazine(s) or other publications, online or print distribution  Broadcast by radio or television  CU Denver | Anschutz marketing and public relations materials/publications  By University of Colorado University Communications to document the progress of my care | | | |
| **Description of Protected Health Information to be Used or Disclosed:** | | | |
| All Patient Identifying Information; or  Age/Date of Birth  City of Residence  Nature of Injuries/Illness | Other:  Name, photo, condition and treatment related to story. | | Not applicable |

I understand that, in the instance of external sources (such as media outlets or law enforcement agents), the University of Colorado facility is acting only as the intermediary, making it possible for the aforementioned source(s) to contact me.

As such, I relieve and hereby agree to hold University of Colorado University Communications and/or University of Colorado and the facility free and harmless from any and all liability arising out of the use and/or release of information; interview; photograph/videotape/film; and subsequent publication or broadcast. I understand that the interview(s) or photo session(s) are being carried out upon my consent and authorization and so assume full responsibility.

I understand that:

1. I may refuse to sign the authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may be redisclosed by the recipient and may no longer be protected by federal privacy regulations.
5. I understand that I may see/obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

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| This authorization will expire on the following: (check and complete only one box) |
| Date: When the University no longer has need for the image/video |

I have read the above and authorize the disclosure of the protected health information as stated.

|  |  |
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| **Signature of Patient/Guardian/Patient Representative or Employee/Volunteer/Physician:** | **Date:** |
| **Print Name of Patient’s Representative:** | **Relationship to Patient:** |