Print Form

University of North Carolina Health Care System
101 Manning Drive
Chapel Hill, NC 27514

PATIENT PHOTOGRAPH/VIDEO & INFORMATION RELEASE AUTHORIZATION FORM- MIM #739

NOTE: This form is NOT required for photos or videos of patients used for the purposes of treatment or diagnosis, where the photo and/or video becomes part of the patient's medical record and is not used for any other purpose.

Photography/Videography Release:

I authorize the University of North Carolina Health Care System ("UNC HCS") to take photographs and/or videos, or to allow third parties to take photographs and/or videos, of _____ [patient name] for the following uses:
(check all that apply)

For Public Relations Purposes

- ☐ On UNC HCS internet and intranet sites
- ☐ In UNC HCS publications and brochures
- ☐ In the public media, such as newspapers, magazines, on the internet, and on television
- ☐ In presentations, publications, brochures, advertisements, or articles by non-UNC HCS agencies or companies, such as other non-profit organizations or for profit companies who provide support to UNC HCS

For Medical or Educational Purposes

- ☐ In professional journals and other publications, including textbooks and electronic publications
- ☐ In presentations by UNC HCS faculty, staff, and employees, including professional and educational conferences or seminars
- ☐ In UNC classrooms and other teaching environments
- ☐ Other: _____

☐ I understand that the image(s) I've authorized for disclosure may be seen by members of the general public. If I've authorized release of image(s) for medical or educational purposes, I understand that the images may be seen by scientists, medical researchers, and medical students and teachers, as well as by members of the general public.

Information Release:

☐ **I consent to the use of my name.** I understand that I may be identified by name in printed, internet or broadcast information that might accompany the photo or video image of me.

-OR-

☐ **I do not consent to the use of my name.** I understand that, even though my name will not be used, it is possible that someone may recognize me based on the image(s) alone.

☐ I authorize the use of the following information about me, my medical condition, or my treatment: _____

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I understand that:

- I may revoke this Authorization at any time:
  - the revocation will not apply to information that has already been released in response to this Authorization.
  - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the Office of Public Affairs & Marketing, 20610 North Carolina Neurosciences Hospital, 101 Manning Drive, Chapel Hill, NC, 27514.
- I may refuse to sign this Authorization:
  - UNC Health Care System will not condition my treatment, any payment, enrollment in a health plan, or eligibility for benefits on receiving my signature on this Authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected by federal and state privacy laws.

Unless otherwise revoked, this authorization will expire on the following date (mm/dd/yyyy) , event, or condition _____
(if left blank, this authorization will expire one year from the date it is signed).

I have read and understand the information in this Authorization form.

Signature of Patient:	
Printed Name:	
Date and Time: (mm/dd/yyyy)	

OR

Signature of Authorized Representative:	
Printed Name:	
Date and Time: (mm/dd/yyyy)	
Please explain Representative's authority to act on the behalf of the Patient:	

Witness _____ Date and Time: _____

For filing, please complete and sign/date this form, then **fax** to Medical Information Management at **(919) 966-0839** .
Questions about filing? Call 919-966-2312