University of Colorado Medicine

UNIVERSITY OF COLORADO MEDICINE MODEL/SPEAKER RELEASE AND/OR AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name:	Birth Date:
Person(s) or Class of Persons Authorized to <u>Use/Disclose</u> the Information: University of Colorado Medicine	**Persons Authorized to <u>Receive</u> the Information:** University of Colorado Medicine

Participant 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, television or social media platforms
☐ CU Anschutz marketing and public relations materials/publications
☐ University of Colorado Medicine to document the progress of my care

If a Patient, Please Include 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 Medicine 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.

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.

Signature of Speaker/Model/Patient/Guardian/Patient Representative:	**Date:**
Print Name of Representative:	**Relationship:**