UTMB
The University of Texas Medical Branch

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PHOTOGRAPHY, VIDEO/AUDIO RECORDINGS AND/OR TELEVISED SESSIONS OF PATIENTS

(Images to be used or disclosed for purposes other than treatment, payment and/or health care operations)

Patient Name: _____
Last **First** **M.I.**

Date of Birth: **UH Number:**

1. The following information can be used and/or disclosed: *(check all that apply and provide a description)*
   - ❑ Photographs _____
   - ❑ Other digital images _____
   - ❑ Video/Audio Recordings _____
   - ❑ Other: _____
2. I authorize UTMB to disclose the information (as described above) to:

Name: _____

Address: _____

City, State, Zip **Telephone Number:**

3. If this authorization is for any purpose other than the release of PHI for personal reasons, please state the purpose below:

_____

4. This authorization will expire on the 180th day of the signing or as otherwise specified below:

_____

5. I understand this authorization is voluntary and I may refuse to sign. UTMB may not withhold treatment based on the completion of this authorization.
6. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care.
7. I understand that I may revoke this authorization at any time by notifying UTMB in writing to the Health Information Management Department, 301 University Blvd, Galveston, Texas 77555-0782 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by UTMB before UTMB received my written notice of revocation.
8. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws.

_____ _____
Signature of the Patient or Personal Representative Date