Authorization to Use Image/Personal Information in Public Communications

I agree to allow UW Health to use information about me, including my name, my voice and/or photos or videos of me in public communications such as printed materials, electronic communications, use on UW Health web sites, in UW Health advertising and in social media.

I will let UW Health identify me to external parties for use in printed, broadcast or web news stories. I agree to participate in photographs, videos and interviews with reporters from external news media. I understand that such videos, photos and interviews may be rebroadcast or reprinted by other media outlets as well.

If a UW Health patient, I agree to be identified as a patient.

Special instructions/restrictions:_____

This agreement will remain in effect unless you revoke your authorization.

I am: ❍ A Patient ❍ Other _____

_____
Name – Last, First, MI

_____
Street Address

_____
City State Zip Code

_____
Birthdate Phone Number Email Address

Signature (*Individual or Parent/Guardian**)_____**Date** _____

If this form has been signed by the patient's legal representative, please indicate your relationship to the patient: _____

*Generally, if you are 18 years of age or older, you are the only person permitted to sign this form to allow the use of your image or discuss of information about you. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact UW Health Marketing and Communcations at: (608) 262-6343.

ADDITIONAL INFORMATION REGARDING USE AND DISCLOSURE OF PATIENT INFORMATION

You should be aware of the following guidelines in signing this agreement:

No Obligation to Sign. You do not have to sign this form, and you may refuse to do so. Unless permitted by applicable law, UW Health Care Providers may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to take away this authorization. Your written revocation will be effective except to the extent that the person(s) and/or organization(s) listed on this form have taken action in reliance on this authorization. Your revocation must be made in writing and addressed to UW Health Marketing and Communications, 301 S. Westfield Road, Suite 250, Madison, WI 53717 or e-mailed to news@uwhealth.org.

Re-release. If the person(s) and/or organization(s) you are allowing to use your image/personal information are not health care providers or people subject to federal health privacy laws, information they receive, may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to inspect. You have the right to inspect or copy information for which you are authorizing use or disclosure, with certain exceptions provided under state and federal law. If you would like to inspect the information to be disclosed, contact the UW Health Marketing and Communications office at (608) 262-6343.

For more information. Visit: uwhealth.org/hipaa

UW Health includes University of Wisconsin Medical Foundation, Inc., University of Wisconsin Hospitals and Clinics Authority, and UW School of Medicine and Public Health and other affiliated entities.

FOR OFFICE USE ONLY

Project Description _____

Physical Identification _____

Job Number _____ Department _____ Staff Initials _____

Event _____ Event Date _____ Event Location _____

Tag(s) _____

PATIENTS ARE ENTITLED TO A COPY OF THIS FORM AFTER SIGNING

UW Health