University of Iowa Health Care Consent Form

Print

Authorization for Release of Information and/or Public Use of Image (Photograph or Videotape)

Clear All Fields

Send copy of completed form to Health Information Management (HSSB, Suite 100) to be scanned into patient's medical record. (Non-patient forms are retained by the department acquiring consent).

MRN: _____

TO BE COMPLETED BEFORE PATIENT/VISITOR OR PATIENT/VISITOR'S REPRESENTATIVE SIGNS THIS AUTHORIZATION.

_____ _____

Patient or Visitor's Name (please print) Patient/Visitor's Birth Date

_____ _____ _____ _____

Address City State Zip Code

_____ _____ _____

Home Phone Work or Cell Phone E-mail

_____ _____

Signature of Patient/Visitor or Patient/Visitor's Representative Date

_____ _____

Printed name of Patient/Visitor's Representative Relationship to Patient/Visitor

_____

OR Legal Authority (attach supporting documentation)

_____

Today's Date

UNIVERSITY OF IOWA HEALTH CARE

Sample photo of patient/visitor for internal use.

_____

Intended Use (but not limited to)

I agree to allow the University of Iowa/UI Health Care/UI Center for Advancement to interview, video record, and/or photograph me (or the person named above for whom I give this permission, in which case all referenced to "my" throughout this consent shall be considered as references to the person named above). I understand that the University of Iowa/UI Health Care/UI Center for Advancement may use my name, my image, and/or my spoken or written comments for promotional uses. I understand that these promotional uses may include feature stories, advertisements, videos, or other formats that will appear in public media. I agree to allow the University of Iowa/UI Health Care/UI Center for Advancement to use my name, comments, and/or image for up to six (6) years without additional approval. I understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that once this information is disclosed, it may no longer be protected by federal privacy regulations. I understand that this authorization is voluntary and that I may revoke this authorization at any time by providing written notice to the following address: UI Health Care Marketing and Communications, 200 Hawkins Drive, W319 GH, Iowa City, IA 52242-1009. I understand that if I revoke this authorization, it will not affect any actions taken by UI Health Care prior to it receiving my written notification. I understand that I may call 319-356-1009 with any questions I have regarding this authorization.

Intended Use: Presentation or Publication of Case Report

_____I agree to allow the University of Iowa/UI Health Care to report pertinent details of my care in an academic setting or publication, including but not limited to, a professional conference or academic journal. My name, birthdate, and medical record number will not be disclosed in any text or images, including photographs or radiological imaging, of the report. Details of my care and treatment may include my age at presentation to UI Health Care, diagnosis, laboratory and clinical findings and images, course of treatment or therapy, and outcomes.