University of Colorado Hospital

UNIVERSITY OF COLORADO HEALTH

University of Colorado Hospital or
University of Colorado Denver| Anschutz Medical Campus
PATIENT CONSENT TO PHOTOGRAPH/VIDEOTAPE/FILM/INTERVIEW AND/OR AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:	**Birth Date:** **Medical Record Number:**
Person(s) or Class of Persons Authorized to <u>Use/Disclose</u> the Information:	**Person(s) or Class of Persons Authorized to <u>Receive</u> the Information:**

Patient consents to be:

☐ Photographed ☐ Filmed ☐ Videotaped ☐ Interviewed ☐ None of the foregoing

☐ Other: ______________________________

Purpose of Use/Disclosure:

☐ Broadcast by radio or television
☐ Published in newspaper, magazine, website or other publication
☐ University of Colorado Hospital/University marketing and public relations materials/publications
☐ University of Colorado Hospital/University to document the progress of my care
☐ University of Colorado Hospital/University for educational uses as a demonstration for others

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:	☐ Not applicable

I understand that:

1. If information is being requested by external sources (such as media outlets or law enforcement agents), the University of Colorado Hospital is only the go-between. (UCH makes it possible for that other source(s) to contact me.)
2. I may refuse to sign this authorization. This is strictly voluntary.
3. If I do not sign this form, my health care and the payment for my health care will not be affected.
4. I may decide at any time that I don't want to do this. I must then withdraw this authorization in writing. If I do, it will not have any effect on any actions taken before the withdrawal of my authorization.
5. All rights, title and interest in the photography or interview belong to the institution checked above. I will not receive financial compensation for their use.
6. It is possible that if the requester or receiver is not a health plan or health care provider, that the released information possibly may be disclosed by the receiver of the information. It may possibly no longer be protected by federal privacy regulations.
7. I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
8. 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: ______________ ☐ Event: ______________ ☐ 180 days from date signed

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	**Date:**
Print Name of Patient or Patient's Representative:	**Relationship to Patient:**
Signature of Attending Physician/Designee and Title:	**Date:**