AUTHORIZATION for Use or Disclosure PHOTO/VIDEO

SAINT LOUIS UNIVERSITY

I authorize Saint Louis University to take photographs and record video images of my face or body.

Images may include personal statements and voice recordings.

Patient Name _____

Purpose: (*check all that apply*)

- ☐ Education and training of healthcare professionals, administrators, and students
- ☐ Patient and/or family education
- ☐ Publication or broadcast by the news media
- ☐ For external or internal publications or presentations
- ☐ Other (specify) _____

Photos/Images may be used for reproduction, publication, or exhibit presentation. They may be transmitted and distributed individually or in conjunction with other images or printed matter, including by not limited to video tapes, sound recordings, still photographs, digital reproductions or any other form of media.

Person / Organization to receive information:

_____

Description of Photographs/Video to be used or disclosed:

_____

_____

I hereby waive the right to inspect or approve my image or any finished materials that incorporate my image. I understand and agree that I will receive no compensation, now or in the future, in connection with the use of my Image. I understand that the use of my image by the University may cause my status as a patient of the University and my medical diagnosis to become generally known in the community.

I hereby release and forever discharge the University, its Trustees, officers, agents and employees from any and all claims, demands, rights and causes of action of whatever kind that may arise from the use of my image, including but not limited to, all claims for defamation and invasion of privacy.

Expiration

This authorization shall expire at such time as the University no longer uses the image(s) for Medical Center publicity, unless I specifically revoke my authorization in writing as explained in the University's notice of privacy statement. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

I understand that if the organization authorized to receive my image is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

APPROVAL (You or your Personal Representative must sign and date this form for completion.)

Patient:

_____
(Print Name)

_____
(Signature)

_____
(Date)

Patient Representative: The person who has legal authority to act on behalf of the individual. A copy of a Healthcare Power of Attorney or other legal document must be on file or submitted with this form.

_____
(Printed Name of Personal Representative)

_____
(Signature of Personal Representative)

_____ _____
(Date) (Description of Authority)