AUTHORIZATION for Use or Disclosure PHOTO/VIDEO

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 _____

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

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:

Patient Representative: The person who has legal authority to act on behalf of the individual. A copy of a Healthcare Power of

_____
(Print Name)

_____
(Signature)

_____
(Date)

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