



UNIVERSITY OF COLORADO
HOSPITAL

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Aurora, CO 80045



UNIVERSITY OF COLORADO
HEALTH SCIENCES CENTER

4200 East Ninth Avenue, Mail Stop A092
Denver, CO 80262

**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: <input type="checkbox"/> Photographed <input type="checkbox"/> Filmed <input type="checkbox"/> Videotaped <input type="checkbox"/> Interviewed <input type="checkbox"/> None of the foregoing <input type="checkbox"/> Other: _____	
Purpose of Use/Disclosure: <input type="checkbox"/> Publication in newspaper(s), magazine(s) or other publications <input type="checkbox"/> Broadcast by radio or television <input type="checkbox"/> University of Colorado Hospital/UCD marketing and public relations materials/publications <input type="checkbox"/> By University of Colorado Hospital to document the progress of my care	
Description of Protected Health Information to be Used or Disclosed:	
<input type="checkbox"/> All Patient Identifying Information; or <input type="checkbox"/> Age/Date of Birth <input type="checkbox"/> City of Residence <input type="checkbox"/> Nature of Injuries/Illness	<input type="checkbox"/> Other: _____ <input type="checkbox"/> Not applicable

I understand that, in the instance of external sources (such as media outlets or law enforcement agents), the University of Colorado facility is acting only as the intermediary, making it possible for the aforementioned source(s) to contact me.

As such, I relieve and hereby agree to hold University of Colorado Hospital and/or University of Colorado Denver and the facility free and harmless from any and all liability arising out of the use and/or release of information; interview; photograph/videotape/film; and subsequent publication or broadcast. I understand that the interview(s) or photo session(s) are being carried out upon my consent and authorization and so assume full responsibility.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may be redisclosed by the recipient and may no longer be protected by federal privacy regulations.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

This authorization will expire on the following: (check and complete only one box)		
<input type="checkbox"/> Date: _____	<input type="checkbox"/> Event: _____	<input type="checkbox"/> 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 or Employee/Volunteer/Physician:	Date:
Print Name of Patient's Representative:	Relationship to Patient: