

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)