

Patient Name _____ Medical Records # _____
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**SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE  
 PATIENT CONSENT AND AUTHORIZATION TO BE PHOTOGRAPHED,  
 FILMED, VIDEOTAPED AND/OR INTERVIEWED**

I, \_\_\_\_\_ hereby authorize Southern Illinois University School of Medicine (“SIU”), in partnership with \_\_\_\_\_ to photograph or otherwise record and use, reproduce, publish, distribute, broadcast, and exhibit my image, likeness, and/or voice, by still or moving pictures, digital photographs or recordings, videotape, audiotape, and printed or other media (including, without limitation, the Internet and any electronic data interchange formats such as YouTube), for advertising, news, promotion and/or educational purposes, such as presentations, and publications, and shall include but is not limited to the following purpose(s): \_\_\_\_\_.

I understand and agree that such photographs and/or other recordings, and all copyrights and other rights and interests therein, shall be owned exclusively by SIU. I further understand and agree that such photographs and other recordings may be scanned into computers and adjusted electronically and may be edited, cropped, or otherwise modified by SIU at its discretion.

I understand that the information related to my medical care and treatment may be used or disclosed in the course of the purposes described above. I understand that the disclosure of such information is voluntary. I further understand that any disclosure of information comes with the potential for re-disclosure and therefore the information may not be protected by federal privacy rules. I understand that this authorization may be revoked at any time by submitting a written statement to the address listed below\*. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I can refuse to sign this authorization for any purpose other than for certain treatments that need to be documented in the medical record in order to meet the standard of care. See separate signature line below. I understand I may inspect or copy the information to be used or disclosed, as provided in Code of Federal Regulations Section 164.524. If I have any questions about disclosure of my health information, I can contact SIU’s privacy officer in writing. \*This authorization shall not expire unless expressly requested by the patient for any use and disclosure for the purposes of education, including but not limited to, presentations, publications, and seminars. This authorization shall expire two (2) years from the date herein for all other purposes, including but not limited to, advertising and media relations.

I hereby expressly release SIU, its employees and agents, from any and all claims or demands that I might have against any of them to any remuneration or damages in connection with the use of the photographs and other recordings referred to herein.

IN WITNESS WHEREOF this permission form is executed this \_\_\_\_\_ day of \_\_\_\_\_.

STAFF:

\_\_\_\_\_  
 School of Medicine Representative

\*Privacy Officer  
 SIU School of Medicine  
 PO Box 19621  
 Springfield, IL 62794

\_\_\_\_\_  
 Signature/Designee

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City, State, ZIP

\_\_\_\_\_  
 Telephone

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 Signature for Patients Only Authorizing for Treatment Purposes