UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS **Permission to Release Information Including Photographs, Videos, Electronic or Other Media**	MRN (REG #): PATIENT NAME BIRTHDATE: CSN:

Please identify yourself: ☐ **Patient** ☐ **Volunteer** ☐ **Other** (specify): _____

Name: _____ DOB: ___/___/_____ (mm/dd/yyyy)

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Permission to Release:

I give the University of Michigan and agencies acting on its behalf permission to release information about me, including information about my health. This may include photographs, videos, electronic or other media involving me. ☐ Yes ☐ No

The items may also be released to any radio, television, internet, print or other media outlet. ☐ Yes ☐ No

The items may be used by the University including its public relations and marketing units and by the media indefinitely for educational, promotional, public relations, or marketing purposes. ☐ Yes ☐ No

Exceptions: Information may only be released according to the following guidelines.

_____

_____

Liability Release: I understand that the released items may be disclosed to students or trainees, to media outlets, and to the general public. Once released outside the University of Michigan, my information will no longer be protected. I release the University of Michigan, its agents, employees and any other persons involved with taking or producing these items from any and all liability that might arise as a result.

Revoking Permission: I understand that I can revoke this permission at any time by contacting the UMHS Public Relations and Marketing Communications department at (734) 764-2220. However, I also understand that the University has no control over disclosures made outside the University before I revoke my permission. A copy of this form is available upon request.

Release is Voluntary: I understand this permission is voluntary. I do not have to release my information, and whatever I decide will not affect my health care and will not affect my participation in any research study.

_____

Signature of Patient, Volunteer, Visitor, or his/her Legally Authorized Representative (if he/she is a minor or unable to sign)

_____ **Date:** ____/____/_____

Printed Name of Legally Authorized Representative (if he/she is a minor or unable to sign) (mm/dd/yyyy)

Relationship: ☐Spouse ☐Parent ☐Next-of-Kin ☐Legal Guardian ☐DPOA for Healthcare

70-10069	VER: A/11 HIM: 12/11	Medical Record	University of Michigan Hospitals and Health Centers	Permission to Release Information Including Photographs, Videos, Electronic or Other media

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