

Photo Consent Form

University of Iowa Health Care
University of Iowa Roy J. and Lucille A. Carver College of Medicine

AUTHORIZATION FOR RELEASE OF INFORMATION AND/OR PUBLIC USE OF IMAGE (PHOTOGRAPH OR TAPE) TO THE UNIVERSITY OF IOWA CARVER COLLEGE OF MEDICINE.

I hereby give my consent to participate in a promotional story, advertisement and/or image (photograph and/or videotape) made for University of Iowa Health Care (or the person named below, for whom I am giving consent). I have been told that this story, advertisement and/or image (photograph or videotape) may appear in the public media, including print, internet and/or broadcast media for a period up to six (6) years. I have been told that this story, advertisement and/or image (photograph and/or videotape) may be used more than once for promotional purposes by UI Health Care.

Subject Name (Please Print)

Date

Address

City

State

Zip

Home Phone

Work Phone

E-Mail

I have been informed that once information is disclosed it may no longer be protected by federal privacy regulations. I have been informed that this authorization is voluntary and that I may revoke this authorization at any time by notifying Alumni and Collegiate Relations in writing: The University of Iowa Carver College of Medicine, Office of Alumni and Collegiate Relations, 5105 Westlawn, Iowa City, IA, 52242. The revocation will not affect any actions taken before the receipt of this written notification.

Signature of Subject or Subject's parent or legal guardian

Date

Printed name of Subject or Subject's parent or legal guardian

Subject's Birth Date

Relationship to Subject