

EVMS MEDICAL GROUP
CONSENT TO USE PHOTOGRAPHS/VIDEOTAPES/FILMS/INTERVIEWS WITH
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name:	Phone:
Consent for/Description of Protected Health Information to be Used or Disclosed (check all that apply): <input type="checkbox"/> Photograph <input type="checkbox"/> Film <input type="checkbox"/> Videotape <input type="checkbox"/> Interview <input type="checkbox"/> Other: _____ <input type="checkbox"/> All Identifying Information <input type="checkbox"/> Name <input type="checkbox"/> Age/Date of Birth <input type="checkbox"/> City of Residence <input type="checkbox"/> Other:	
Description of Protected Health Information to be Used or Disclosed:	
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"/> Other (specify): _____	
Description of Protected Health Information to be Used or Disclosed:	
<input type="checkbox"/> All Patient Identifying Information; or <input type="checkbox"/> Nature of Injuries/Illness	<input type="checkbox"/> City of Residence <input type="checkbox"/> Age/Date of Birth
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Not applicable

I hereby authorize EVMS Medical Group to release the information above and agree to hold EVMS Medical Group 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 information previously gathered for and contained in my medical record is being released 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 requestor 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 will receive a copy of this form after I sign it.

This authorization will expire on the following: (check and complete only one box)

Date: _____
 Event: _____
 180 days from date signed

I have read the above and authorize the disclosure of the protected health information as stated. (For a minor, at least one parent or legal guardian signature is required)

Signature:	Date:
Printed Name :	
Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Parent or Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Personal Representative: describe authority to act _____ <input type="checkbox"/> Other: _____	
Signature:	Date:
Printed Name:	
Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Parent or Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Personal Representative: describe authority to act _____ <input type="checkbox"/> Other: _____	
Signature of Witness:	Date:
Printed Name & Title:	