UNIVERSITY of IOWA HEALTH CARE

Photo Consent Form

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

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 Marketing and Communications, Division of External Relations in writing: University of Iowa Health Care, Division of External Relations, 4144 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 _____