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):

☐ Photograph ☐ Film ☐ Videotape ☐ Interview ☐ Other: _____

☐ All Identifying Information ☐ Name ☐ Age/Date of Birth ☐ City of Residence

☐ Other:

Description of Protected Health Information to be Used or Disclosed:

Purpose of Use/Disclosure:

☐ Publication in newspaper(s), magazine(s) or other publications ☐ Broadcast by radio or television

☐ Other (specify): _____

Description of Protected Health Information to be Used or Disclosed:

☐ All Patient Identifying Information; or ☐ Nature of Injuries/Illness	☐ City of Residence ☐ Age/Date of Birth	☐ Other:	☐ 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: ☐ Self ☐ Parent or Guardian ☐ Power of Attorney ☐ Personal Representative: describe authority to act _____ ☐ Other: _____	
Signature:	**Date:**
Printed Name:	
Relationship: ☐ Self ☐ Parent or Guardian ☐ Power of Attorney ☐ Personal Representative: describe authority to act _____ ☐ Other: _____	
Signature of Witness: **Printed Name & Title:**	**Date:**