University of Colorado Colorado Springs

Patient Name(s)

Medical Record #

Date of Birth

Contact Phone #

HIPAA Authorization for Release of Health Information – Media

I hereby authorize University of Colorado Colorado Springs (UCCS) Designated Health Care Components to use and disclose information about me for the purposes of creating press releases, news stories, photographs or video clips, website and/or publications, as well as stand-alone pictures/graphics in which I may appear and/or be heard, for use in internal UCCS publications and/or disclosure to external (non-UCCS) media.

The information about me may include my: name, treatment modality, age, duration of treatment, treatment plan, diagnoses, city and state of residence, photographs, location of UCCS treating facility and information about my life and how I came to UCCS or my on-going treatment. The information may also be disclosed to external media in the form of press releases, stories, photographs or video clips. It may also be used for internal purposes or on the UCCS website or through UCCS's own marketing or educational campaigns. UCCS will not receive any direct or indirect payment from or on behalf of any third party in exchange for the release of this information about me.

I understand the provision of health care treatment, payment for my health care and my health care benefits are not dependent on this authorization. I understand I am not required to sign this authorization. The information will not be used or disclosed without authorization. I understand any information used or disclosed pursuant to this authorization may be subject to redisclosure.

I understand I have the right to revoke this authorization in writing, except to the extent information has already been released pursuant to this authorization at the time of the revocation. I can revoke this authorization by sending correspondence to the UCCS Director of Campus Compliance / Privacy Officer, 1420 Austin Bluffs Parkway Colorado Spring CO 80918.

I hereby release, discharge and agree to hold UCCS harmless from any liability that may arise from the release of information authorized above.

This authorization shall expire 10 years from date of signature.

_____ _____

Signature of Patient or Authorized Representative **Date of Signature**

_____ _____

Printed Name **Relationship to Patient (if applicable)**

If the patient is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the Patient named above and I am not prohibited by Court Order from releasing access to the requested information.

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Patient Testimonial Consent and Release Agreement

I, the undersigned, grant to University of Colorado Colorado Springs (UCCS) perpetual right and license to use, reproduce, print, publish, broadcast and rebroadcast, as well as to copyright, my testimonial statement, voice, picture, name and likeness in any and all media and types of advertising and promotion (collectively referred to as "Advertising") for the UCCS and their products and services.

All right, title, and interest in and to my name, testimonial statement, voice, picture, and likeness used in Advertising pursuant to this Consent and Release, including all copyrights therein, will be the sole property of the UCCS, free from any claims whatsoever by me or my employer.

I understand that I will not have any right to compensation in connection with the UCCS use of my name, testimonial statement, voice, picture, or likeness. I hereby release UCCS and their successors and assigns from any and all claims arising out of their use of my name, testimonial statement, voice, picture, and likeness as agreed to in this Consent and Release, including without limitation any claims based on libel, slander, or the rights of publicity, privacy or personality. I hereby waive any right to review any Advertising and agree that no advertisement or other material need be submitted to me for any further approval.

I acknowledge that this permission authorizes UCCS to post my testimonial statement, voice, picture, name, and likeness on third party social media web sites (including Facebook, Twitter, Instagram, and YouTube), which may require UCCS to grant the owners and users of such sites a broad license to use such materials for any purpose without notice to or approval from me.

The statements attributed to me in any testimonial I provide reflect my actual experience with UCCS and my honest opinions about UCCS Covered Entities and/or their products and services. I understand that I have the right to revoke this authorization in writing, by sending correspondence to the UCCS Director of Campus Compliance / Privacy Officer, 1420 Austin Bluffs Parkway Colorado Spring CO 80918. If I revoke this authorization, it will not impose any obligation upon UCCS to recall or destroy any materials already used, published or disclosed.

This Consent and Release does not in any way conflict with any existing commitment on my part. I am of the age of 18 or older and have the right to contract in my own name and, if applicable, on behalf of my employer with respect to this Consent and Release. I understand that the provision of health care treatment, payment for my health care, and my health care benefits are not dependent upon this Consent and Release.

I understand that this Consent and Release does not obligate UCCS to make any use of any of the rights granted herein.

_____ _____

Signature of Releasor or Authorized Representative **Date of Signature**

_____ _____

Printed Name **Relationship to Patient (if applicable)**