Authorization for Audio Recordings, Photography, or Other Images for Non-Treatment Purposes

I hereby authorize the ________________________________ at ________________________________ to make audio recordings or to take photographs, videotape, or digital images of me ("Images"). I understand that UT Southwestern Medical Center may use and release my images to the general public for the following purposes: (1) educational lectures and presentations for health care professionals; (2) scientific publications such as journals or books; (3) patient education materials; (4) broadcast, print or internet media for educational or public interest purposes.

I understand that after release of my images to the general public, they may be subject to redisclosure.

I understand that this authorization is voluntary and I may refuse to sign. UT Southwestern Medical Center may not condition my health care services on the completion of this authorization.

Unless otherwise revoked, I understand that this authorization will expire 50 year(s) from the date of signature. I understand that I may revoke this authorization at any time, except to the extent that UT Southwestern Medical Center has relied on this authorization, by sending a written statement of revocation that specially refers to this authorization to:

UT Southwestern Medical Center
Attn: ________________________________
5323 Harry Hines Blvd.
Dallas, Texas 75390

I hereby release UT Southwestern Medical Center, The University of Texas System and its Regents, officers, agents and employees from any and all liability connected with the capture, use or release of my images.

By signing this authorization I acknowledge that I have read and understand the statements contained herein. I understand that UT Southwestern Medical Center will provide me with a copy of this signed authorization form.

Patient:
Print Name: ________________________________
Signature: ________________________________
Date: ________________________________

If Patient Has a Legal Representative, Complete the Following:
Print Name of Patient: ________________________________
Print Name of Legal Representative: ________________________________
Relationship to Patient: ________________________________

By signing this authorization, I certify that I have the legal authority to serve as the above named patient’s legal representative.

Signature of Legal Representative: ________________________________
Date: ________________________________

*For more information on qualifications to serve as patient’s legal representative, see UT Southwestern’s Guidelines for Legal Representative.