AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION: NAME, IMAGE AND ART WORK THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

Name _____Date of Birth _____

_____ _____

P.O. Box, Apt. No., Street City State Zip Medical Rec# (if known) or Employee #

I, _____(name) hereby permit and authorize the University of Mississippi Medical Center ("UMMC") and its employees, agents, and personnel who are acting on behalf of UMMC to use my name, my photograph, video images, recorded testimonials, art work or other likenesses of me ("Works"), for advertising purposes of UMMC including, but not limited to, marketing and promotion of UMMC and its various programs and if art, for published materials, and news and feature stories. I understand that UMMC may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that the Works may be copied and distributed by means of various media, including but not limited to newspapers, wire services, the broadcast media, video presentations, press releases, mailouts, billboards or signs, brochures or placement on web sites.

ADDITIONAL INFORMATION

You should know that any Works released could potentially be released again by the person receiving them and no longer protected by federal privacy regulations. You have the right to take back this authorization at any time. If you do so, it does not affect Works that have already been released or that are in the production process prior to the date of request for revocation. To revoke your permission, send a written notice, which has been signed and dated by the authorized person, to UMMC at the following address: Attention: Office of Compliance, The University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216-4505. Send a copy to Marketing at the same address. The notice should have the following information on it: (1) name (2) a description of the information and material about you that UMMC had permission to release; (3) the name or other specific identification of the media, person(s), or class of persons, that UMMC was going to send the information to, if known and (4) the date that the permission was signed. You also should know that the use of your name, image, interview, any and all representation of you will be in approved effect for ten (10) years unless you provide UMMC/Marketing with a request to withdraw this consent, through the above procedure. A photocopy of this authorization shall be considered as effective and valid as the original.

I have carefully read and understand the above and I have received a copy of this authorization. I herein expressly and voluntarily sign this authorization.

_____ _____

Signature or Personal Representative Date

(Form must be completed before signing)

_____

Description of Personal Representative's Authority

_____ _____

Witness Date

_____ _____

Signature of University of Mississippi Medical Center Representative Date

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.