UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

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along with signed Form B to the
Office of HIPAA Privacy & Security

RESEARCH AUTHORIZATION/RELEASE FOR PHOTOGRAPHY OR AUDIO/VIDEO RECORDINGS

Patient Name: _____ Last 4 Digits of SSN: _____

Medical Record Number: _____ Phone Number: _____

Address: _____

I, _____, authorize the University of Miami, Department of _____ to take still photographs, audio recordings, and/or video recordings of me/(my child), and I authorize the release and publication of any protected health information or other identifying information in connection with such activity (as applicable), for use in any manner, as indicated below ***(please read, check the appropriate box, and describe activity or list the publication in the space next to the appropriate permission statement)***.

☐ Publication(s) or other broadcast, promotional, advertising, or commercial purposes:
_____

☐ Medical Training, teaching, education, scientific meetings and scientific publications, including professional journals or medical books: _____

☐ Other: _____

I hereby release all claims, rights, and interests that I might have in such photography or audio or video recordings or use thereof. I agree that the University of Miami, its Trustees, officers, employees, students, faculty, and agents will not be responsible for any claims arising in any way out of the taking and use as described above of such photographs and/or audio or video recordings, and that I will not receive any benefit from the use of such photographs or recordings. I understand that I will not have an opportunity to inspect and approve such photographs or recordings prior to their use, and that the University of Miami will be the owner of such photographs and/or recordings. I confirm that these photographs and/or recordings were taken with my knowledge and consent.

_____ _____
Location of Activity Date of Visit

_____
Description of photographs or audio/video recordings, for identification purposes

If additional space is needed, write on the back and check this box ☐

_____	_____	_____
Signature of Patient	Print Name	Date
_____	_____	_____
Witnessed by	Print Name	Date
_____	_____	_____
Patient Representative/Relationship	Print Name	Date

_____
Patient Date of Birth *(if less than 18 years of age or otherwise lacks legal capacity)*

_____	_____	_____
Name of Department Representative	Department	Dept. Phone Number

University of Miami – Office of HIPAA Privacy & Security
PO Box 019132 (M-879) **hipaaprivacy@med.miami.edu**
Miami, FL 33101 **305-243-5000 1-866-366-4874**

AUTHORIZATION/RELEASE FOR PHOTOGRAPHY OR AUDIO/VIDEO RECORDINGS

Form D3900055S Research Revised 2/23/10

NAME: _____
MRN: _____
LAST 4 DIGITS OF SSN: _____
DOB: _____
DATE: _____ TIME: _____