UCLA Health System

PATIENT NAME: LAST	FIRST
MEDICAL RECORD NUMBER	
DATE OF BIRTH	SEX M F

PLEASE ATTACH DEMOGRAPHIC LABEL OR FILL IN ABOVE INFORMATION

PATIENT PERMISSION TO USE IMAGES AND MEDICAL INFORMATION IN NEWS STORIES OR PROMOTIONAL MATERIALS

UCLA is committed to protecting the privacy of our patients' medical information. That's why we must obtain your written consent before we can photograph you or reveal details about your care for use in news stories or promotional materials. Please review the following facts and assure your questions are fully answered by a UCLA Health System communications officer before signing this form. You are entitled to receive a signed copy.

FREQUENTLY ASKED QUESTIONS

Who will disclose my medical information? Only you and your team of medical caregivers may provide details about your case to a UCLA Health System communications officer.

Who will use my information? A UCLA Health System communications officer may share your images or information with journalists or the public for promotional purposes, such as advertising, brochures, Web pages, publications or news stories.

What happens after my photos and information go public? Once stories, photos, audio and videotape enter the public domain, it's important to understand that other outlets are free to use them, too. For example, photos and stories in the Los Angeles Times are often picked up by news wires, reprinted by other newspapers and Web sites, and broadcast by radio and television stations.

Before you sign this form, make sure you are comfortable with the amount of public recognition you may receive. UCLA Healthcare cannot control how -- or for how long -- news outlets use or distribute your information, photos and videotape for future stories. We also cannot guarantee that other organizations will not display your publicized images or information on their own Web sites.

I'm not sure I want to make my information public. Do I have to sign this form? Absolutely not! Signing this form is your choice alone and will have no effect upon your medical care, fees or insurance benefits.

May I withdraw my consent? You may cancel or revoke your authorization at any time by writing to UCLA Health Sciences Media Relations, 924 Westwood Blvd, Suite 350, Los Angeles, CA 90095; however, if we have already used the information and disclosed it as provided by the authorization, we will not be able to revoke your authorization.

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When does my consent expire? Unless specified by you, this form expires on _____. If no date is recorded, your consent expires 12 months after the date of your signature.

Please list specific information you do NOT want disclosed:

Type of Activity: (to be completed by communications staff)

You agree to participate in an interview, provide details about your medical care and/or have photographs, audio or video recordings made of you, for:

- □ UCLA Health System brochure or publications
- □ UCLA Health System Web site(s)
- □ UCLA Health System-related stories in the news media, including but not limited to newspaper, television, radio, magazines and online publications.
- □ Marketing/advertising by UCLA Health System, including possible storage in a photo or video archive for future promotional purposes
- □ Other:

Signature

I have read this form, and all of my questions have been answered. My signature confirms that I understand and accept all of the above conditions, and approve the use of my images and private health information by UCLA Health System.

_____	_____	_____
Signature (Patient or Guardian)	Print Patient Name	Date
_____	_____	_____
Relationship to Patient	Email Address	Phone(s)

_____
Mailing Address

_____	_____	_____
Print UCLA Rep's Name	Signature	Date