MICHIGAN MEDICINE **Permission to Release Information Including Photographs, Videos, Electronic or Other Media**	MRN (REG #): PATIENT NAME BIRTHDATE: CSN:

STAFF: Patient Information above is required if document is sent to Health Information Management

Please release the information for the following person (mark only one):

☐ Patient listed in upper right **or** ☐ Volunteer **or** ☐ Visitor/Family/Other (specify): _____

Name (first and last): _____ DOB: ____/____/_____ (mm/dd/yyyy)

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Permission to Release:

I give Michigan Medicine and agencies acting on its behalf permission to release information about me, including information about my health. This may include photographs, videos, electronic or other media involving me.	☐ Yes ☐ No
The items may be released to any radio, television, internet, social media, print or other media outlet.	☐ Yes ☐ No
The items may be used by Michigan Medicine including its public relations and marketing units and by the media indefinitely for educational, promotional, public relations, or marketing purposes.	☐ Yes ☐ No

Exceptions: Information may only be released according to the following guidelines.

_____

_____

Liability Release: I understand that the released items may be disclosed to students or trainees, to media outlets, and to the general public. Once released outside Michigan Medicine, my information will no longer be protected. I release Michigan Medicine, its agents, employees and any other persons involved with taking or producing these items from any and all liability that might arise as a result.

Revoking Permission: This authorization has no expiration date; but I understand that I can revoke this permission at any time by contacting Michigan Medicine Department of Communication at (734) 764-2220. However, I also understand that Michigan Medicine has no control over disclosures made outside Michigan Medicine before I revoke my permission. A copy of this form is available upon request.

Release is Voluntary: I understand this permission is voluntary. I do not have to release my information, and whatever I decide will not affect my health care and will not affect my participation in any research study.

_____

Signature of Patient, Volunteer, Visitor/Family/Other, or Legally Authorized Representative (if person is a minor or unable to sign)

_____ **Date:** ____/____/_____

Printed Name of Legally Authorized Representative (if person is a minor or unable to sign) (mm/dd/yyyy)

Relationship: ☐Spouse ☐Parent ☐Next-of-Kin ☐Legal Guardian ☐DPOA for Healthcare ☐Other (specify):_____

70-10069	VER: A/18 HIM: 10/18	Medical Record	MICHIGAN MEDICINE UNIVERSITY OF MICHIGAN	Media Release Authorization

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