Reporting, Publication or Broadcast Release

Patient Name: _____ Date of Birth: _____

Address: _____ Tel: _____

As a patient of the University of Illinois Hospital and Health Sciences System (UI Health), the law requires your (or the patient's) written permission before UI Health can give out any health information that can identify you (or the patient) to the public, including news media or allow the news media to photograph, record, or interview you (or the patient) while at UI Health. You will also be asked for your permission to use your (or the patient's) resulting photograph(s), recording(s), and/or interview(s) for various purposes.

You (or the patient's) written permission is voluntary and the care you (or the patient) receive and the health insurance/benefits you (or the patient) have do not depend on signing this permission.

As used in your (or the patient's) permission, the term "Photograph(s)" includes film, digital photographs, video images, movies, audio recordings, and live streaming videos created as well as the tape, digital, or resulting electronic recordings or images, prints, negatives, computer graphics, or images.

1. I give my permission for UI Health to give out; share; release health information – specified in #2 - that can identify me (or the patient) for unlimited use in any news report, publication, or broadcast (including on the Internet) and for any promotional, marketing, advertising, or commercial purpose to:

   - The Board of Trustees of the University of Illinois ("University") outside UI Health, and
   - Reporters for local, state, and national broadcast news media including newspapers, magazines, television, radio, Internet, and social media sties ("Reporters").

2. Health information may include my (or the patient's) name, age, condition, course of treatment(s), diagnosis(es), prognosis, Photograph(s), and description(s) of injury(ies) and/or disease(s). I understand that this may include sensitive health information regarding AIDS/HIV, Drug/Alcohol Abuse, Mental Health, Sexual Assault, Child Abuse, or Disabilities. I impose no specific restrictions regarding what type of health information is given out; shared; or released other than:

3. I also give my permission for UI Health to permit University staff and Reporters to Photograph and interview me while at UI Health for unlimited use in any news report, publication, or broadcast (including on the Internet) and for any promotional, marketing, advertising, or commercial purpose. I understand that I am responsible for any information I voluntarily give out; share; or release.

4. I understand that the University and Reporters are not covered by HIPAA and what is given out; shared; or released may no longer be protected by this law. I understand that there is no compensation to me (or the patient). I understand that Photographs taken by the University or Reporters are their respective property. I understand the University or Reporters may receive compensation or some benefit in using my (or the patient's) health information and Photographs.

5. I understand that my permission is valid for ten (10) years unless I cancel or revoke it in writing to the University's Department of Public and Government Affairs. My (or the patient's) written revocation will not affect any giving out; sharing; or release made before receipt of my (or the patient's) written revocation.

_____	_____	_____
Signature of Patient or Personal Representative	Relationship to Patient (if applicable)	Date
_____	_____	_____
Signature of Witness	Print Name of Witness	Date

A signed copy of this permission should be attached immediately to the patient's medical record.
A copy of this authorization is as effective as the original.