Authorization to Report, Publish, or Broadcast

Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

The Board of Trustees of the University of Illinois (University) runs the University of Illinois Hospital & Health Sciences System (UI Health). UI Health includes all components/pieces of the University that provide health care, and health-related services or activities. UI Health is regulated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal and state health privacy laws. These laws require your written permission before UI Health can reveal, in any way, health-related information about you or associated with you. **Your written permission is voluntary and neither the care you have received or may receive from UI Health nor the commercial health insurance or government health care benefits you receive depend on signing this permission**.

The University is also seeking your written permission on behalf of itself and reporters for local, state, and national broadcast news media (Reporters) (e.g., newspapers, magazines, television, radio, Internet, and social media sites) to photograph, film, record, live stream, or interview you in the context of, or in association with, the health information revealed by UI Health for their publication or broadcasting.

1. I give my permission for UI Health to give, share, release, or reveal health information – specified in #2 – about me or associated with me to (1) the University and (2) Reporters for their unlimited use.

2. The health information UI Health can give, share, release, or reveal includes, but is not limited to:
    - Permitting University staff and Reporters access to me in the context of, or in association with, receiving care or my presence or association with a health-related event, activity, location, or health-related condition.
    - My name, age, condition(s), course of treatment(s), diagnosis(es), prognosis, photograph(s), and description(s) of injury(ies) and/or disease(s).

I understand health information may include AIDS/HIV, Drug/Alcohol Abuse, Mental Health, Sexual Assault, Child Abuse, or Disabilities. I impose no specific restrictions other than: _____.

I understand the University and Reporters are not covered by HIPAA and what is given out, shared, released, or revealed by UI Health may no longer be protected by law.

3. I also give my permission for (1) University staff and (2) Reporters to photograph, film, record, live stream, or interview me 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 I am responsible for any information I voluntarily give, share, release, or reveal. I understand there is no compensation to me for my participation but the University or Reporters may receive compensation or some benefit in using my image or likeness alone or in combination with my health information. I understand the University or Reporters, respectively, own the resulting images, audio recordings, and videos created as well as any resulting prints, negatives, graphics, copies, or derivatives thereof.

4. 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. I understand my written revocation will not affect or change any activities that occur before it is received.

Signature of Individual or Personal Representative	Print Name and Relationship to the Individual	Date
Signature of Witness	Print Name of Witness	Date

A copy of this authorization is as effective as the original

Updated: March 6, 2018