Vanderbilt University Medical Center

MEDIA RELATIONS - AUTHORIZATION TO CREATE, USE, OR DISCLOSE PHOTOGRAPHS OR VIDEOS FOR MEDIA RELEASES AND PUBLIC RELATIONS

PATIENT IDENTIFICATION

Name: _____

Date of Birth_____

Signed original will be filed in the Office of News & Public Affairs and a copy will be provided to the patient.

MEDIA RELEASES AND PUBLIC RELATIONS

Yes No N/A I authorize members of the VU Media and Public Relations staff (including but not limited to the Office of News & Public Affairs, Medical Center Marketing, the Medical Arts Group and Medical Center Development) and other VU personnel, to make and publish photographs, videos, or written/audio accounts that document my (or the patient's) condition or treatment in newspapers, magazines, other publications, television, motion pictures, Internet, or other media, which will be circulated to the general public for news, marketing, business, or any other purpose, or to provide access to members of the public media to do the same (name of media outlet(s), if applicable): _____.
I understand that there is a possibility that I (or the patient) may be identifiable in these photographs, videos, or written/audio accounts, though my (or the patient's) name will not be published unless I specifically agree below.

☐ I DO ☐ I DO NOT consent to the use of my (or the patient's) name with these photographs or videos.

I release any and all rights or claims for payment or royalties in connection with any exhibition, televising, or other showing of these motion pictures, videotapes, or photographs, regardless of whether such exhibition, televising, or other showing is under philanthropic, commercial, or private sponsorship, and regardless of whether a fee of admission or film rental is charged.

I agree to release and hold harmless Vanderbilt University, its trustees, agents, officers, and employees from any liability related to the making or use of motion pictures, videotapes, or photographs for the purposes stated above.

I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my/the patient's ability to obtain treatment. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance of this authorization.

I understand that the information released may be subject to re-disclosure by some recipients and may no longer be protected by federal or state privacy rules related to health information.

Authorization for use in treatment or at patient or family's request will not expire. Authorization for other uses and disclosures indicated above will expire 10 years from the date of signature, however, I acknowledge VU is unable to control the continued use of photographs or videos by non-VU personnel after expiration of this authorization.

Signature of Patient/ Legal Guardian: _____ **Date:** _____

Relationship to Patient: _____

To revoke this authorization, please send a written request with a copy of this form to the address below:

Medical Center News and Public Affairs
CCC-3312 Medical Center North
Vanderbilt University Medical Center, Nashville, TN 37232-2390

If you have any questions please call Medical Center News and Public Affairs at (615) 322-4747