THE UNIVERSITY OF KANSAS HEALTH SYSTEM

ST. FRANCIS CAMPUS

Authorization to Use and Disclose Images, Voice Recordings and/or Testimonials

Patient Name: _____ Date of Birth: _____
Address: _____ Phone Number: _____

1. I hereby authorize The University of Kansas St. Francis Campus ("Provider") to use and disclose the following information about the individual listed above ("Patient"): (a) photographs, digital images and other visual recordings that contain Patient's image, likeness and/or other Patient identifiable health information, including, if applicable, images of Patient taken before and after the receipt of services from Provider; (b) recordings of Patient's voice and other audio recordings containing Patient identifiable health information; (c) biographical information and other protected health information about Patient, including any information included in testimonials or reviews provided by Patient in oral, written, video or other form; and (d) information indicating that Patient received medical services from Provider and describing such services and Patient's diagnosis.

2. Provider may use and disclose the information described above in, and to create, marketing materials, publications, websites, presentations, advertisements and any other distribution media, including using and disclosing Patient's information in print media, on the radio, TV, Provider's website, blogs and social media platforms, such as Facebook, Twitter, LinkedIn and YouTube. Any person or entity who receives, encounters or views these items or accesses Provider's website, marketing materials or other media may obtain this information. The purpose of this use and/or disclosure is to promote and provide publicity to Provider. Provider may contract with third parties to capture the image, voice or other information described above, and the information may be used and disclosed by these third parties consistent with this authorization.

3. This authorization will remain in effect until revoked by Patient unless state law requires a shorter time period. This authorization may be revoked at any time by sending a written notice to Provider at The University of Kansas St. Francis Campus, Attn: Privacy Officer. However, expiration and/or revocation will not effect on any uses or disclosures already made by Provider in reliance on this authorization. For example, Patient's information may continue to appear in promotional materials created or released by Provider prior to receiving the revocation for so long as those materials are distributed, disseminated or have not expired, and information may continue to be available on the internet, social media and other media for an indefinite time even when it is no longer included on Provider's website or Provider's other promotional materials. Once Patient's information is used and/or disclosed pursuant to this authorization, it may be further used or disclosed by the recipient(s) and may not be protected by the HIPAA Privacy Rules (45 CFR Parts 160 and 164). I understand that I may refuse to sign this authorization and that Provider will not condition treatment of Patient on whether I sign this authorization.

4. Patient will receive no financial compensation for the use of Patient image or other information as described in this authorization. Provider **will not** receive financial remuneration (compensation) from third parties in exchange for the use and disclosure of Patient's information.

Signature: _____ Date: _____

Print name: _____

If signed by personal representative, describe relationship: _____