UT Southwestern
Medical Center

Authorization for Audio Recordings, Photography, or Other Images for Non-Treatment Purposes

Pt. Name:____

Address:____

____
City State Zip

DOB: ____

SSN: XXX-XX-___ ___ ___ ___ SEX:______

I hereby authorize the____ at
(insert department name)
UT Southwestern Medical Center to make audio recordings or to take photographs, videotape, or digital images of me ("Images"). I understand that UT Southwestern may use and release my images to the general public for the following purposes: (1) educational lectures and presentations for health care professionals; (2) scientific publications such as journals or books; (3) patient education materials; (4) broadcast, print or internet media for educational or public interest purposes.

I understand that after release of my images to the general public, they may be subject to redisclosure.

I understand this authorization is voluntary and I may refuse to sign. UT Southwestern may not condition my health care services on the completion of this authorization.

Unless otherwise revoked, I understand that this authorization will expire 50 year(s) from the date of signature. I understand that I may revoke this authorization at any time, except to the extent that UT Southwestern has relied on this authorization, by sending a written statement of revocation that specially refers to this authorization to:

UT Southwestern Medical Center
Attn:____________________ Department
(insert name of department)
5323 Harry Hines Blvd.
Dallas, Texas 75390

I hereby release UT Southwestern Medical Center, The University of Texas System and its Regents, officers, agents and employees from any and all liability connected with the capture, use or release of my images.

By signing this authorization I acknowledge that I have read and understand the statements contained herein. I understand that UT Southwestern will provide me with a copy of this signed authorization form.

Patient:

Print Name: ____

Signature: ____

Date: ____

If Patient Has a Legal Representative, Complete the Following:

Print Name of Patient: ____

Print Name of Legal Representative: _______________________________

Relationship to Patient:____

By signing this authorization, I certify that I have the legal authority to serve as the above named patient's legal representative*.

Signature of Legal Representative:____

Date:_________________________

*For more information on qualifications to serve as patient's legal representative, see UT Southwestern's Guidelines for Legal Representative.