

AUTHORIZATION to Use or Disclose De-identified Health Information for Publication and Educational Purposes

Patient's Name	Date of Birth	Verification of Identity (Driver's License, ID Card, Passport, etc.)
Patient's Address	Medical Record Number	

** Complete the following only if the person authorizing the use or disclosure is not the patient:

Representative's Name	Relationship to Patient	Legal Authority
Representative's Address	Verification of Identity	Verification of Authority

By signing this form, I authorize the following:

Disclosure of the patient's information from :		Disclosure of the patient's information to :	
<i>Entity or organization where the images were made:</i>		<i>Person or organization who will use/disclose the images:</i>	
<i>Address</i>		<i>Address</i>	
<i>Attn:</i>	<i>Phone</i>	<i>Attn:</i>	<i>Phone</i>

- **The following health information may be disclosed:** (*Check all that apply*)
 - Video taken during surgery or other health care encounter and related health data.
 - Photographs taken during surgery or other health care encounter and related health data.
 - Other images recorded during surgery or other health care encounter (*describe*) _____
No identifiable information (name, address, etc.) or images (face or other uniquely identifiable body parts) will be included with or in the videos, photographs, or medical data.

- **I further authorize** the disclosure of the following information which may be included in the health information listed above. (*Check all that are approved.*)
 - Mental Health Substance Abuse HIV/AIDS

- **This health information will be used or disclosed only for educational purposes**, which may include publication in books or journals, or classroom instruction and/or medical training at the University of Florida, other educational institutions, and/or national and international conferences.

I understand that, by federal law, the University of Florida may not use or disclose *protected health information* (health information which identifies or could reasonably be expected to identify, a person) without authorization except as provided in the University's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosures of the health information described above. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.

I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

I understand that information disclosed pursuant to this Authorization may no longer be protected by any medical privacy laws and could be redisclosed by the person or agency that receives it.

I have the right to inspect and/or receive a copy of the Health Information released.

This authorization expires automatically after: <input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years	
I understand that the expiration will not apply to any actions already taken as a result of this authorization.	
I have read and understand the information in this authorization form.	
Signature of Patient or Legal Representative:	Date