

## **AUTHORIZATION FOR VIDEO, AUDIO, RECORDING, AND PHOTOGRAPHIC PARTICIPATION AND INTERVIEWS**

Subject's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail: \_\_\_\_\_

This authorization pertains to a specific project, request, event and/or use (specify):

\_\_\_\_\_

This authorization does not pertain to a specific request, project, event and/or use.

I authorize UPMC to photograph (still photo, film, videotape, or digital imagery/video), record (audiotape or digital) and/or interview me, using either a UPMC staff photographer/videographer and/or reporter, or a photographer/videographer and/or reporter approved by UPMC. I understand that UPMC, and in some cases the organization with which it has partnered, has / shall have all legal rights to the photography / recording(s) / interview(s) and that I give up any and all rights to these organizations and will not receive any payment or compensation for the same now or in the future. I understand the photography/recording(s) / interview(s) may be used for publicity, education, public information, or paid advertising by UPMC and that the photography / recording(s) could appear on UPMC's website and/or elsewhere on the Internet. I hereby release and discharge UPMC, its subsidiaries, and its and their employees, agents, and representatives from any claims, liability, or results caused by the use of such photography/recording(s) and/or interview of me as provided herein.

**By agreeing to be interviewed about health care services received from UPMC, I also authorize UPMC, at its discretion, to interview my UPMC doctor(s), nurse(s), and/or other caregivers to confirm, supplement, and/or clarify the information provided in my interview. I understand that such staff interview(s) may result in a limited disclosure of my protected health information (PHI), in the form of facts necessary to ensure the accuracy of any account based on my interview, but that no medical records will be released.**

**I understand that whether I choose to sign this authorization will in no way influence the health care services provided to me by UPMC. Additionally, I understand that I will not receive any special services or compensation in exchange for my agreeing to sign this authorization.**

I understand that I may revoke this authorization at any time by providing written notice to UPMC addressed to: UPMC Marketing Communications, 600 Grant St. Floor 57, Pittsburgh, PA 15219. However, such revocation shall not affect UPMC's right to use information, photography / recording(s), and / or interviews made or obtained prior to my revocation of this authorization.

Subject's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The subject is unable to consent on his/her own behalf because \_\_\_\_\_

I am the authorized representative of the subject, on the following relationship or basis \_\_\_\_\_

\_\_\_\_\_ and hereby provide such authorization on behalf  
of the subject.

Signature of Subject's Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_