University of Colorado **Anschutz Medical Campus**

UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS MODEL/SPEAKER RELEASE AND/OR AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name:	**Birth Date:**
Person(s) or Class of Persons Authorized to Use/Disclose the Information:	**Persons Authorized to Receive the Information:**

Participants Consent to be: (check all that apply)

☐ Photographed ☐ Filmed ☐ Interviewed ☐ None of the forgoing

☐ Other:

Purpose of Use/Disclosure: (check all that apply)

☐ CU Anschutz marketing purposes, including internal/external publications and social media sites

☐ External media (e.g., news stations, newspapers)

☐ Speaking at a CU Anschutz event

☐ CU Anschutz to document the progress of my care

If a Patient, Please Include Description of Protected Health Information to be Used or Disclosed: (check all that apply)

☐ All Patient Identifying Information; or ☐ Age/Date of Birth ☐ City of Residence ☐ Nature of Injuries/Illness	☐ Other: Name, photo, condition and treatment related to story	☐ Not applicable

I understand that, in the instance of external sources (such as media outlets or law enforcement agents), the University of Colorado facility is acting only as the intermediary, making it possible for the aforementioned source(s) to contact me.

As such, I relieve and hereby agree to hold University of Colorado Anschutz Medical Campus Office of Communications and/or University of Colorado and the facility free and harmless from any and all liability arising out of the use and/or release of information; interview; photograph/videotape/film; and subsequent publication or broadcast. I understand that the interview(s) or photo session(s) are being carried out upon my consent and authorization and so assume full responsibility.

By signing this document the undersigned consents to the University using my image as well as all information related for any the purposes checked above. I hereby grant to the University of Colorado Anschutz Medical Campus the absolute and irrevocable right and unrestricted permission to use photographic portraits, editorials, video, digital or film images, or any pictures taken of me, to use, re-use, publish and re-publish the same in whole or in part, individually or in conjunction with other photographs and any printed or videographic matter, in any and all media now or hereafter known, and for any purpose whatsoever allowed by law for illustration, promotion, art, editorial, advertising and trade, or any other purpose whatsoever without restriction as to alteration; from time to time, in conjunction with our own or a fictitious name, or reproduction thereof in color, black and white or otherwise made through any media. This authorization is valid for 10 years unless I revoke it in writing prior to that time.

I understand that:

1. I may refuse to sign the authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may be redisclosed by the recipient and may no longer be protected by federal privacy regulations.
5. I understand that I may see/obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Speaker/Model/Patient/Guardian/Patient Representative:	**Date:**
Print Name of Representative:	**Relationship:**

The American Board of Plastic Surgery

Patient photographic Consent for Oral Examination for Dr. Jason W. Yu, D.M.D. M.D.

I hereby grant permission for use of any medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing, and/or certifying pursposes by The American Board of Plastic Surgery, Inc.,

Patient Name: _____ Signature: _____

Witness Name: _____ Signature: _____

Date: _____