Springfield clinic

Medical Record Number: _____-_____-_____

Authorization to Photograph and Release Medical Images

I, _____ (_____), hereby authorize and consent to the use of my image by Springfield Clinic for:
(Patient Name) *(Date of Birth)*

PLEASE CHECK ALL APPROPRIATE CHOICES IN BOLD TYPE:

1. PLACEMENT IN MY MEDICAL RECORD FOR:

___Documentation of the extent of my illness, injury, or anomaly
___To provide visual comparisons of my response to treatment in order to determine effectiveness of care

2. SUBMISSION FOR:

___Preauthorization/precertification for proposed medical/surgical treatment to secure payment verification
___Consultation required for evaluation, diagnosis, second opinion, and/or treatment recommendations
___OTHER (state reason) _____

3. OR PRODUCTION OF:

___Internet/intranet web postings*
___Use in medical research/education/science purposes
___Patient education within the provider's practice
___Television/Printed Article (state media company/publication name)_____
___Use in treatment presentations for patient support groups
___Other (state reason) _____
___All of the above
___Marketing pamphlets*
___Live public educational forums

** I have been informed that media releases may include disclosure to media company personnel, or other parties involved in the publication, including other medical providers and/or subcontractors involved in the production effort.*

Release from:
(Provider) _____
Springfield Clinic, LLP
P.O. Box 19248
Springfield, IL 62794-9248

Release To:
(Receiver Name) _____
(Organization) _____
(Address) _____
(City/State/Zip) _____

Specific types of information authorized to be disclosed, are listed below [*CIRCLE APPROPRIATE NUMBERS*]:

1. Images of my [condition and/or body part(s)]_____, which **may/may not include** my facial features and/or other identifying marks such as tattoos or physical anomalies.

2. Summary information regarding the condition, diagnostics utilized, treatment plan, follow up course, and recovery period for the above-listed condition to explain images.

3. My identifying information (as defined by federal privacy rules).

PLEASE SPECIFY ANY ASPECT OF THE ABOVE INFORMATION THAT YOU WISH TO HAVE EXCLUDED FROM RELEASE:

_____

NOTE: Images may be modified/retouched as deemed appropriate by my provider for formal publication.

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THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE MUST READ AND INITIAL THE FOLLOWING STATEMENTS:

1. I understand that I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it. **Initials: _____**

2. I understand that I may revoke this authorization at any time by notifying the Springfield Clinic Privacy Office in writing, but the revocation will not affect any actions which they have taken prior to the receipt of the written revocation. Without express written revocation directed to the Springfield Clinic, I understand that this **authorization will expire five years from today's date**. **Initials: _____**

3. I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand and acknowledge that the confidential healthcare information disclosed and used pursuant to this authorization may be subject to re-disclosure by the receiver. I have been made aware that if the receiver re-discloses my information, it may no longer be protected by federal privacy regulations, and that Springfield Clinic is not liable for any consequences of such re-disclosure. **Initials: _____**

_____ _____
Signature of patient or patient's legal representative Date

_____
Printed name and representative's relationship to patient

_____ _____
Printed Name and Title of Springfield Clinic Witness Date

Facsimile reproductions of the signature are acceptable.