MEDIA AUTHORIZATION FORM

Name:_____

Address:_____ City:_____ State:_____ ZIP: _____

Description of Information to be released:

_____

_____

Reporter/Affiliation:_____ Possible air/publication date: _____

Consent to: ☐ interview ☐ photography ☐ videotape ☐ other

I authorize Nebraska Medicine/University of Nebraska Medical Center (Hospital/UNMC) and its employees and agents to disclose/publish to the public my information, image, likeness, voice, and comments as relevant to the box(es) selected above. I understand my voluntary participation in this media campaign may reveal information on my condition or the medical/behavioral services I received from Hospital/UNMC. I understand this information may be used by Hospital/UNMC in connection with advertising, publicity, promotion or other media purposes, which could include producing newspaper or magazine articles, television programs, videotape recordings, internet materials and other visual and/or audio recordings.

☐ I authorize having my name identified with the materials. ☐ I prefer not to be identified by name.

I understand I do not have any proprietary rights in the materials produced or any rights to inspect or approve the finished materials prior to publication or the use to which it may be applied. I have had the opportunity to ask questions about the potential uses of the interview/photograph/videotape or other materials to be produced.

I understand that once disclosed publicly the information may be redisclosed or used by the public and no longer be protected by state and federal law.

I understand that Hospital/UNMC ☐will/☐will not receive compensation for its use/disclosure of the information.

This authorization shall expire only in the event that I withdraw my authorization. I understand that I may withdraw this authorization in writing at any time by notifying the Privacy Office in writing at 988102 Nebraska Medical Center, Omaha NE 68198-8102 or by calling toll free at 1-800-552-8802, Ext. 9-5136. I understand that Hospital/UNMC may not be able to honor my request to withdraw this authorization if Hospital/UNMC has already acted in reliance on my authorization.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment (if applicable).

_____ _____

Signature of Individual | Signature of parent, guardian, or authorized Representative

_____ _____

Date | Relationship of above person to individual

_____

Witness

University of Nebraska Medical Center℠ Nebraska℠ Medicine