

Place Patient Label Here

Print Patient Name _____

**UAMS OFFICE OF COMMUNICATIONS
HIPAA AUTHORIZATION TO ALLOW ACCESS TO PATIENTS
AND TO RELEASE PATIENT INFORMATION**

I, _____ hereby authorize UAMS to allow the entities indicated below to have access to me for the purpose of ___ photographs, ___ video recording, and ___ audio recording:

___ The UAMS Communications and Marketing Department (501) _____

MEDIA:

___ Television _____

___ Radio _____

___ Print _____

___ Other _____

In addition, I hereby authorize UAMS to release to the above-named party: (if applicable)

_____ my current treatment information

_____ my current medical condition

1. **Purpose of access or release:** At Request of Patient.
2. **Expiration Date** – This Authorization expires ninety (90) days from the date I sign the Authorization, unless I specify otherwise by writing in an earlier or later date: _____
3. **Revocation of Authorization** – I understand that I am not required to sign this Authorization. If I sign this Authorization, I may revoke the Authorization at any time by giving written notice to the UAMS Office of Communications. A revocation of this Authorization will not apply to records, information, photography, or audio/visual recordings already released in reliance upon the Authorization. A photocopy or faxed copy of this signed Authorization shall constitute a valid authorization.
4. **Release of Liability** – I agree that UAMS, including UAMS employees and attending physicians, are hereby released from legal responsibility or liability for the access provided and the release of the above information to the extent indicated and authorized herein.
5. **Re-Disclosure** – I understand that once the above information is disclosed, it may no longer be protected by privacy laws and regulations if such laws and regulations do not apply to the designated recipient, and it may be re-disclosed by the designated recipient.
6. UAMS will not condition treatment, payment, enrollment or eligibility for benefits on your signing of this Authorization.

Signature of Patient or Legal Representative _____ Date _____

If Legal Representative has signed on behalf of Patient, state the authority of Legal Representative to do so:

(such as parent of a minor, court-appointed guardian, attorney-in-fact appointed in a Power of Attorney)

Office Staff: Provide Copy of Signed Authorization to Patient/Legal Representative