# Authorization for the Use or Disclosure of Identifying Images

The University of Kansas – The University of Kansas Medical Center – KU HealthPartners, Inc.

I, _______________________________________________, born on ______________

**OR**

I, _______________________________________________, born on ______________

Parent/Guardian of ____________________________ Relationship _______________

Street Address ___________________________________________________________

City ____________________________________ State ________ Zip _____________

Phone __________________ E-mail Address _______________________________

hereby give permission for the University of Kansas (KU), including but not limited to, the University of Kansas Medical Center, and KU HealthPartners, Inc. (KUHP), to use or disclose photographs or other identifying images of me (or my child), and limited information about my (or my child's) medical condition. I will be asked to approve the medical information that is shared.

My (my child's) information and identifying images will be used to publicize and promote the activities of KU and KUHP. Examples of uses include but are not limited to: publicly-available media articles, newsletters, brochures, posters, video, newspaper/journal advertisements and Web sites. I understand that KU and/or KUHP has sole discretion in determining appropriate uses of the photographs taken pursuant to this authorization.

I may decline to sign this Authorization; this will not affect my treatment or services at KU or KUHP.

I understand that some persons or groups who receive information about me or my child may not be required to comply with federal privacy laws, and information disclosed to these persons/groups will no longer have federal privacy protection.

I have the right to cancel this authorization at any time in writing, except to the extent that it has already been acted upon. I may cancel my authorization by writing to: Public Relations Coordinator, KU Schools of Allied Health & Nursing, Mail Stop 2006, 3901 Rainbow Boulevard, Kansas City, KS 66160. Unless I cancel it, this authorization will remain in effect indefinitely.

I may receive a signed copy of this authorization upon request.

**I, ____________________________, have read the above information and authorize KU and KUHP to use and disclose my identifying images and limited medical information according to the terms stated above.**

_____________________________________________________________________________

Signature of Patient/Client or Legal Representative Date

Office of the Dean
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