

VANDERBILT UNIVERSITY  
MEDICAL CENTER

**PATIENT AUTHORIZATION**  
TO CREATE, USE, OR DISCLOSE  
PHOTOGRAPHS OR VIDEOS FOR MEDIA  
RELEASES AND PUBLIC RELATIONS

Signed original will be filed in the Medical Center Office of News & Communications, and a copy will be provided to the patient upon request.

**Yes**  **No** I authorize members of the VUMC Media and Public Relations staff (including but not limited to the Medical Center Office of News & Communications, Medical Center Strategic Marketing and Medical Center Development), and other Vanderbilt University/VUMC personnel to make and publish photographs, videos, or written/audio accounts that document my (or my child's) condition or treatment in newspapers, magazines, other publications, television, motion pictures, Internet, or other media, which will be circulated to the general public for news, marketing, business, or any other purpose, or to provide access to members of the public media to do the same (name of media outlet (s), if applicable): \_\_\_\_\_

I understand that there is a possibility that I (or my child) may be identifiable in these photographs, videos, or written/audio accounts, though my (or my child's) name will not be published unless I specifically agree below.

**I do**  **I do not** consent to the use of my (or my child's) name with these photographs or videos.

I release any and all rights or claims for payment or royalties in connection with any exhibition, televising, or other showing of these motion pictures, videotapes, or photographs, regardless of whether such exhibition, televising, or other showing is under philanthropic, commercial, or private sponsorship, and regardless of whether a fee of admission or film rental is charged.

I agree to release and hold harmless Vanderbilt University Medical Center, its trustees, agents, officers, and employees from any liability related to the making or use of motion pictures, videotapes, or photographs for the purposes stated above.

I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my/my child's ability to obtain treatment I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance of this authorization.

I understand that the information released may be subject to re-disclosure by some recipients and may no longer be protected by federal or state privacy rules related to health information.

Authorization for use in treatment or at patient or family's request will not expire. Authorization for other uses and disclosures indicated above will expire 10 years from the date of signature; however, I acknowledge VUMC is unable to control the continued use of photographs or videos by non-VUMC personnel after expiration of this authorization.

Patient Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Signature of Patient (if 18 or older) or  
Legal Guardian (if under 18): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

To revoke this authorization, please send a written request with a copy of this form to the address below:

**Medical Center News and Communications**, T-5200 Medical Center North, Vanderbilt University Medical Center, Nashville, TN 37232-2390  
If you have any questions please call Medical Center News and Communications at (615)322-4747