

Consent Form

University of Iowa Health Care

University of Iowa Hospitals and Clinics
University of Iowa Roy J. and Lucille A. Carver College of Medicine

AUTHORIZATION FOR RELEASE OF INFORMATION AND/OR PUBLIC USE OF IMAGE (PHOTOGRAPH OR VIDEOTAPE) DEPARTMENT OF OTOLARYNGOLOGY—HEAD AND NECK SURGERY

In order to assist in the dissemination of medical and scientific knowledge, or in the improvement of medical diagnosis and treatment, I hereby give my consent and authorize the University of Iowa Hospitals and Clinics, members of its staff, and others specifically authorized by the University of Iowa Hospitals and Clinics to: publicly publish, including electronically on-line, display or otherwise use, photographs, videotapes, or other images made of the person named below, for a period up to 25 years. I have been told that my health care and the payment of my health care will not be affected if I do not sign this form.

Patient/Subject Name (please print)

Date

Patient's Hospital #

Address

City

State

Zip

Home phone

Work phone

E-mail

STAFF PHYSICIAN:

VIEWS REQUESTED:

SPECIAL INSTRUCTIONS:

INTENDED USE:

I have been informed that once information is disclosed it may no longer be protected by federal privacy regulations. I have been informed that this authorization is voluntary and that I may revoke this authorization at any time by notifying the Department of Otolaryngology—Head and Neck Surgery in writing: Department of Otolaryngology, University of Iowa Health Care, 200 Hawkins Drive, 21201 PFP, Iowa City, IA, 52242-1078. The revocation will not affect any actions taken before the receipt of this written notification. Questions? 319-356-2173.

Signature of Patient/Subject or Patient/Subject's Representative

Date

Printed name of Patient/Subject's Representative

Patient/Subject's Birth Date

Relationship to Patient/Subject

or

Legal Authority (attach supporting documentation)