UNIVERSITY OF KENTUCKY, CHANDLER MEDICAL CENTER
LEXINGTON, KENTUCKY

Medical Record Number: _____
Department Use Only

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION AND IMAGES

YOU MUST COMPLETE EVERY SECTION BELOW OR THIS FORM MAY BE RETURNED TO YOU TO BE COMPLETED

1.) Identity: Patient Name: _____ Social Security Number: _____

Address: _____ Date of Birth: _____

_____ Phone number: _____

2.) Sender and Receiver:

I authorize disclosure of medical information (as indicated):

From:
(Facility to Disclose Records - See back)
_____
_____
_____

Disclose To: UK Public Relations, UK HealthCare
Marketing, General news media,
_____
_____
_____

3.) Timeframe: I would like records from the following dates: _ through present.

4.) What to disclose: Please check the records you would like disclosed from which facility/location:

HOSPITAL

- ☐ Records related to (specify): _____
- ☐ Discharge summary
- ☐ X-Ray Report(s)
- ☐ X-Ray Film(s)
- ☐ ER Notes
- ☐ Other: (specify) _____
- ☐ Operative Report(s)
- ☐ Pathology Report(s)
- ☐ Laboratory Report(s)
- ☒ Photo/Video/Other

FACILITY/LOCATION (Indicate from choices on back):

- ☐ Records related to (specify): _____
- ☐ Out patient notes
- ☐ Laboratory Report(s)
- ☐ OB/GYN Notes/Reports
- ☐ TB screening
- ☐ X-Ray Report(s)
- ☐ X-Ray Film(s)
- ☐ Psychological test report
- ☐ Other: (specify) _____
- ☐ Pathology Report(s)
- ☐ Immunization Record
- ☒ Photo/Video/Other

5.) Type of Disclosure: ☐ Onsite Review ☐ Paper Copies (☐ Delivered by Mail ☐ Picked up by Receiver)
☒ Media interviews and photo/video filming

6.) Disclosure of special protected records: I authorize the disclosure of information pertaining to:

a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS) ☐ YES ☒ NO/NA
b. The diagnosis or treatment of drug and/or alcohol abuse ☐ YES ☒ NO/NA
c. Treatment and/or consultation for mental health or psychiatric disorders ☐ YES ☒ NO/NA

7.) Purpose of Use/Disclosure: Please indicate/describe each authorized purpose of the use or disclosure:

☐ Request of individual ☐ Marketing (Identify/describe entity/program to be marketed) _____
☒ Public Relations/ News/Media ☐ Other (specify) _____

8.) Expiration date: This authorization will expire in 90 days or January 28, 2030, which ever occurs last.

I understand that I may revoke this Authorization at any time, unless the Authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing to the Registration Office at the Facility/location where I originally submitted/filed this authorization; and that the revocation shall be effective *except* to the extent that the Facility has already used or disclosed information in reliance on the Authorization.
I further understand that treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however, Facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this Authorization, and Facility may condition the provision of research-related treatment on my signing this Authorization.
I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

_____ Date

_____ Signature of Patient

If patient is unable to sign, secure consent of Legal Representative and indicate reason below:
☐ Minor ☐ Incompetent ☐ Deceased

_____ Signature of Legal Representative and Relationship to Patient

_____ Signature of Witness for Psychiatric Records

UK UNIVERSITY OF KENTUCKY

Authorization of Use

☐ **General Use**
☐ Specific Project: _____

I, (*print full name*) _____ (*) hereby grant permission to the University of Kentucky and its affiliates and subsidiaries, including but not limited to the UK Alumni Association, UK Athletics Association and UK Research Foundation, to interview, photograph and/or videotape me, or my minor child, and/or to supervise any others who may do the interview, photography and/or videotaping and/or to use and/or permit others to use information from the aforementioned interview and/or the aforementioned images in educational and promotional activities for the following without compensation:

- ✓ University Educational Publications/Videos
- ✓ University Electronics Publishing (e.g. World Wide Web)
- ✓ Any University Social Media Initiatives
- ✓ University Promotion/Advertising
- ✓ Local/regional/national news media (w/permission of the University of Kentucky)

Signature: _____ Date: _____
Signature

Witness: _____ Date: _____
Signature

Name and mailing address (please print)

Name: _____

Address: _____

_____

E-mail: _____

Phone: _____

If the individual to be interviewed, photographed and/or videotaped is under the age of 18, please indicate your relationship or authority to consent: _____

Signature of Parent or Guardian: _____ Date: _____