AUTHORIZATION FOR THE RELEASE OF
PATIENT'S NAME, IMAGE, PROTECTED HEALTH INFORMATION BY
THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

Patient's name _____ Date of Birth _____

_____ _____ _____ _____
P.O. Box, Apt. No., Street City State Zip

I, _____ (name of patient) hereby permit and authorize the University of Mississippi Medical Center (UMMC) and its employees, agents, and personnel who are acting on behalf of the University of Mississippi Medical Center and its affiliated entities to use my name, my image (photo, video and/or audio), or other likenesses of me, and protected health information (PHI) including name, age, hometown, biographical information, diagnosis, health care treatment and prognosis on news and marketing items, including, but not limited to, feature stories, social media content, photo and video essays, all forms of advertising and press releases produced by UMMC.

I understand that my name, art work, photograph, video image or other likeness and PHI may be copied and distributed to various media outlets, including but not limited to newspapers, wire services, the digital and broadcast media, video presentations, press releases, mailouts, electronic and static outdoor boards or signs, brochures, presentations or placement on UMMC websites. I hereby release, discharge, and agree to hold harmless UMMC from any and all claims, damages, liabilities, costs and expenses that I now have or may hereafter have by reason of any use of my image, likeness or PHI.

I understand that UMMC and affiliated entities and its employees, agents and personnel acting on its behalf, cannot warrant or guarantee that use of my name, photograph, video image, likeness, or health or medical care information by the media and further dissemination of my name, photograph, video image or likeness, or health or medical care information will be subject to UMMC supervision and/or control. Accordingly, I release the University of Mississippi Medical Center, its employees, agents and personnel acting on its behalf from any and all liability related to dissemination of my name, photograph, video image, likeness, health or medical care information.

Unless otherwise indicated or revoked by the patient or Legal Representative (if patient is under the age of 18 or unable to sign), permission for UMMC and its affiliated entities to release the information expires 25 years after the date this authorization is signed. You have the right to revoke this authorization at any time. If you do so, it does not affect the information that has already been released or is currently in the process of being printed or distributed. To revoke your permission, send a written notice, which has been signed and dated by the patient whose authorization it is (or their Legal Representative), to UMMC at the following address: Attention: Office of Compliance, The University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216-4505. The notice should have the following information on it: (1) the patient's name; (2) a description of the information and material about you that UMMC had permission to release; (3) the name or other specific identification of the media, person(s), or class of persons, to which the Medical Center was going to send the information to (if known); and (4) the date that the permission was signed.

You may refuse to sign this Authorization. UMMC will not refuse to treat you if you do not sign this form.

I have carefully read and understand the above, and do herein expressly and voluntarily sign this authorization. I may receive a copy of this signed authorization at my request.

_____ _____
Signature of Patient or Legal Representative Date
(Form must be completed before signing)

_____
Description of Personal Representative's Authority

_____ _____
Signature of University of Mississippi Medical Center Representative Date