

## Authorization for Disclosure of Student Photographs and/or Video/Audio Recordings

Student Name \_\_\_\_\_ Student ID# \_\_\_\_\_

I, \_\_\_\_\_, hereby give my permission and authorize UAMS Northwest to make and disclose photographs or recordings described below to the public for educational, commercial, or other purposes as follows:

**Student: Please strike through and initial the disclosure(s) below that you *do not* authorize, if any.**

1. UAMS internet website(s);
2. UAMS Posters, UAMS Publications, UAMS Photograph Books (by, on behalf of, or about UAMS);
3. Media, Internet Websites, Publications (TV, newspaper, magazine, any other media or websites outside UAMS); and
4. Healthcare-Related Presentations, Seminars, Conferences and Meetings (within and outside UAMS).

### **Additional Health Information Disclosed**

I understand and agree that any photographs/recordings authorized by me may also disclose my Student Protected Information related to my **class year, gender, campus location or class attended(ing)** or other Protected Student Information associated with the photographs or video/audio recordings, and **I authorize this disclosure.**

UAMS is **not** receiving direct or indirect compensation for use/disclosure of the photograph/recordings described in this Authorization.

**Expiration Date** – This Authorization expires **two years** from the date I no longer am a student on this campus, or after the photographs and recordings are no longer needed by UAMS for the use and disclosure that I have authorized, whichever date is later.

**Withdrawal of Authorization** – I understand that I am not required to sign this Authorization. If I sign this Authorization, I may revoke/withdraw the Authorization at any time by giving written notice to UAMS Northwest Student Services 1125 N. College Avenue, Fayetteville, AR 72703. A withdrawal of this Authorization will not apply to records, information, photographs, audio/visual recordings or other information already used/released in reliance upon the Authorization. A photocopy or faxed copy of this signed Authorization shall constitute a valid authorization. **During the recording/filming, I have the right to stop recording/ filming at any time.**

**Release of Liability** – I agree that UAMS, including its governing Board, physicians, agents and employees, are hereby released from legal responsibility or liability for the access and release of my information to the extent indicated and authorized herein.

**Re-Disclosure** – I understand that once the above information is disclosed, it may no longer be protected by privacy laws.

\_\_\_\_\_  
**Student Signature**

\_\_\_\_\_  
**Date**