

## **MEDIA AUTHORIZATION FORM**

Name:			
Address:	City:	State:	Zip:
Description of Information to be released:			
Reporter/Affiliation:	Poss	sible air/publication dat	e:
Consent to:  interview  photo	graphy	ther	
In the interest of education and advancem Medicine/University of Nebraska Medical produce newspaper or magazine articles, and/or audio recordings in which I may be promotion. I have had the opportunity to or other audiovisual.	Center (Hospital/UNMC) and its er television programs, videotape rec included in whole or in part for sh	mployees and agent cordings, internet ma nowing to the genera	s to take photographs, aterials and other visual al public for publicity and
☐ I consent to having my name identified	d with the materials.	er not to be identifie	ed by name.
I grant this authorization and give my conshealth sciences and education. Therefore, rights I may have to inspect or approve the	I waive the following: (1) any prop	orietary rights in the	
I understand that the entities that receive the information described above may be u	•	ed by federal privac	y regulations, and that
I understand that Hospital/UNMC will/	will not receive compensation f	or its use/disclosure	of the information.
I understand that I may refuse to sign this (if applicable).	authorization and that my refusal	will not affect my ak	oility to obtain treatment
I understand that I may withdraw this au	thorization in writing at any time k	oy notifying	
			(staff name/phone)
I understand that Hospital/UNMC may not has already been released.	t be able to honor my request to w	vithdraw this author	ization if the information
I release Nebraska Medicine/University of arising from the use of such materials.	Nebraska Medical Center and its e	employees and agen	ts from any claims
Signature of Individual	Signature of	parent, guardian, or a	uthorized Representative
Date	Relationship	of above person to inc	dividual
Witness			