

MEDIA CONSENT FORM

☐ Patient		☐ UNMC Student		☐ Other:	
First Name		Middle Initial		Last Name	
Date of Birth (MM/DD/YYYY)		Last 4 SSN (optional)		Telephone	
Street Address		City		State	
Description of information to be released. (e.g., status as patient, information about medical condition and related treatment and procedures, photographs, video, interview)					
Limitations/restrictions on use of information to be released (optional)					
A	I do not want the following information about me to be released (e.g., my name, date of birth, image, information relating to psychiatric treatment, chemical dependency or alcohol abuse treatment, or information related to communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), venereal disease, Tuberculosis or Hepatitis)				
B	I do not want my information used in the following manner (e.g. posts on social media, in newspapers, television programs)				
C	Other restrictions on use of my information				

Consent: Except as otherwise stated above, I give Nebraska Medicine/University of Nebraska Medical Center ("ORGANIZATION") permission to create or have others create interview content, photography, images, printed materials, and audio and/or visual recordings and presentations that include information about me and/or my image and likeness ("CONTENT"). ORGANIZATION may use and publicly disclose, or have others use and publicly disclose on behalf of ORGANIZATION, the CONTENT for advertising, promotion, educational and other ORGANIZATION purposes, including but not limited to, written articles, advertisements, internet and social media posts, pamphlets, posters, and presentations. I understand that the CONTENT may reveal that I am/was a patient and other medical and treatment information about me.

Ownership. I understand that I do not own the CONTENT and do not have the right to inspect or approve the finished materials before they are used; I am not entitled to payment or other benefits for use of the CONTENT; and ORGANIZATION may benefit from the CONTENT, but I waive any interest in or claim to such benefits.

Release: I understand that once the CONTENT is disclosed publicly, it may be redisclosed or used by the public and any of my information included in the CONTENT may no longer be confidential or protected by state and federal law. I release ORGANIZATION from any claims arising from the use of CONTENT as authorized in this Media Consent Form.

Revocation: I may revoke my consent to use the CONTENT described above at any time by notifying strategic-comms@unmc.edu in writing. I understand the revocation will not apply to any existing CONTENT but will apply only to the creation and use of new CONTENT. This consent does not expire and will end only when I revoke my consent.

Assurances: I understand that I may refuse to sign this consent and that my refusal will not affect care received at ORGANIZATION, costs of care, or eligibility of benefits. I have had the opportunity to ask questions about the potential uses of the information. I have read this document and fully understand the contents. I also understand that I may request a copy of this consent.

Please print your name and sign below:

Name of Patient, Student or Personal Representative:	Relationship (or Self):
Signature of Patient, Student or Personal Representative:	Date: