Health
University of Missouri

Authorization to Photograph, Videotape, Film, Sound Record or Interview

I, (Print name) _____ authorize The Curators of the University of Missouri (University), its agents and employees, and/or representatives of the news media approved by the University, to photograph, videotape, film and make sound recordings of me, or conduct an interview with me, and use the same in any form for their purposes, including but not limited to educational and promotional purposes. I consent that the photographs, videotapes, films, sound recordings and/or interviews with me may be copied, published either in print or on the World Wide Web, telecast or broadcast for such purposes, together with descriptions and editorial statements. I understand that the information being disclosed may contain individually identifiable health information about me, and I am specifically authorizing the disclosure of such information. This information is being disclosed for the use of the University at my request and agreement.

The use of information under this agreement is designed to enhance the professional development for students in the MU School of Health Professions. The benefits of participation extend beyond student development and translate into public service by preparing future skilled practitioners.

I understand that any individually identifiable health information being disclosed pursuant to this authorization may be subject to re-disclosure by persons receiving it, and may no longer be protected by federal or state privacy laws or regulations. I understand that my treatment or care from any health care provider is not conditioned on me signing this authorization, and I will not be denied medical treatment or care if I do not sign this authorization. I understand that if the University will receive money or other compensation (either directly or indirectly) from someone else because of the use of my health information in the project described above, I have been told of the compensation.

I understand that this authorization may be revoked by me at any time by notifying the University in writing and directed to: Teresa Briedwell, MU Department of Physical Therapy, 828 Clark Hall, Columbia, MO 65211. I understand that any use or disclosure of the individual identifiable health information pursuant to this authorization prior to the effective date of the revocation will not be affected by the revocation. This authorization will continue in effect as long as the University (or any successor entity) continues to operate. I understand that a photocopy or facsimile copy of this authorization will be as valid as the original. I am entitled to receive a copy of this authorization.

All photographs, videotapes, films, sound recordings, written interviews, etc., remain the property of the University and/or external media.

Health
University of Missouri

Signature_____ Date_____

Address _____ City/State/ZIP _____

Phone _____ E-mail _____

Parent or Guardian Should Complete the Section Below for Minors or Individuals with a Legal Guardian

I, _____, certify that I am the _____
(Relationship to minor/individual)

of _____ and authorize the above disclosure on his/her behalf.
(Name of minor/individual)

Signature_____ Date_____

Birth date of minor _____

To Be Completed by the School of Health Professions

Activity: _____

Media: _____

Staff: _____

Description of subject: _____