AUTHORIZATION FOR THE USE OR DISCLOSURE OF IDENTIFYING IMAGES

I, _____, DOB: _____, SS#: _____ consent I authorize University of Kansas Physicians ("UKP") and _____, MD/DO (Physician) to use or distribute identifying images of me, including but not limited to still photographs, digital photographs, videotaped images, scans and/or any other retained images that contain information identifying me or identifiable to me (collectively, "Identifying Images"). I relinquish all right, title and interest in identifying images, or any right to participate or share in any profit or gain realized directly or indirectly through the use of Identifying Images.

I authorize the use or disclosure of Identifying Images by UKP or by Physicians for the following marketing and/or educational purposes:

- **Marketing**: For inclusion in brochures, portfolios, websites, newspaper or other media advertisements and other materials that show examples of treatment or services performed by the physician.
- **Educational**: For use by Physician during or in connection with professional lectures or seminars, in articles submitted, trade and other journals or periodicals, or in educational textbooks for use by health care professionals.

I further authorize the disclosure of Identifying Images by UKP or by Physician to the following persons:

- Health care professionals affiliated with UKP or performing services at KU Medical Center and affiliated locations
- Health care professionals participating in or attending seminars or lectures performed by Physician
- Medical students and nursing students at KU Medical Center
- Examining or Credentialing Boards
- Medical and other periodicals and textbooks
- Editors of medical and other periodicals and textbooks
- Subscribers to medical and other periodicals and textbooks
- Patients and prospective patients wishing to see examples of Physician's past treatment outcomes and results

I acknowledge that I have been informed that: I may request to inspect or copy the identifying image that UKP or Physician intends to use or disclose; I may refuse to sign this Authorization; and treatment or service is NOT dependent upon my signature on this Authorization.

I am aware that once release of this information is made pursuant to this Authorization, this information may be subject to redisclosure by that person or persons and will no longer be protected by the HIPAA Privacy Rule. I reserve the right to revoke this authorization at any time in writing, except for the extent already acted upon.

This authorization expires when Physician is no longer licensed to practice medicine in at least one State in the United States.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

I, _____, have read the above information and authorize UKP and Physician to use and disclose any Identifying Images for the above-described persons. I understand and agree that by signing this document, I release and discharge UKP and Physician from any liability and will hold each of them harmless for any use or disclosure made pursuant to this Authorization.

I further understand that the Identifying Images may be stored and maintained by Physician at such time that Physician terminates Physician relationship with UKP and Physician relinquishes privileges at KU Medical Center, and thereafter. UKP shall have no further responsibility for any use or disclosure of the Identifying Images.

Signature: _____ Date: _____

Print Name: _____ Relation to Patient if Legal Representative: _____