UAMS College of Health Professions
AUTHORIZATION to TAKE and DISCLOSE
PHOTOGRAPHS or VIDEO/AUDIO RECORDINGS

Name of Subject: ____________________________________ Date: _______________
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I hereby consent to the taking of photography, audio/visual recordings or other images of me by UAMS. I understand that the photographs and recording described above may be used by the UAMS College of Health Professions faculty for educational purposes. I also give my permission and authorize the UAMS College of Health Professions to make and DISCLOSE photographs or recordings to the public for educational, commercial, or other purposes as follows:

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

Expiration Date – This Authorization expires after the photographs and recordings are no longer needed by UAMS for the use and disclosure that I have authorized.

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 College of Health Professions Slot # 619, 4301 W. Markham, Little Rock, AR 72205. A withdrawal of this Authorization will not apply to records, information, photographs, audio/visual recordings or other information already used/released in reliance upon original authorization.

A photocopy, faxed, or scanned 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.

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