UNC SCHOOL OF MEDICINE

PATIENT RECORDING AND PROTECTED HEALTH INFORMATION (PHI) RELEASE AND AUTHORIZATION FORM

This section to be completed by the Instructor or Researcher
Instructor/Researcher Name and Dept: _____
Course/Project Name: _____
Date(s) of Recording: _____
Building and Room Number: _____

I, (Patient's name) _____, authorize the University of North Carolina at Chapel Hill, School of Medicine, and Office of Information Systems, to record, using any medium (including, but not limited to, lecture capture, videography, or photography), my image and any personal protected health information for educational and research purposes, including distribution of those recordings and information by any tangible or digital media (e.g. print, DVD, memory card, external storage device), or over the internet.

_____ I understand that I may be identified by name in the recordings, or in any printed, digital, internet, or *(initial here)* broadcast information that might accompany the recorded image of me, and I consent to the use of my name and other identifying information acquired as a result of my participation in the recordings.

-OR-

_____ I do not consent to the use of my name. I understand that even though my name will not be used, it is *(initial here)* possible that someone may recognize me based on the images alone.

I understand that:

- I may revoke this Authorization at any time:
  - The revocation will not apply to information that has already been released pursuant to this Authorization
  - If I want to revoke this authorization, I must do so in writing. The procedure for revoking this Authorization is to present my written revocation to the University of North Carolina School of Medicine, Office of Information Systems, 76 MacNider, CB# 7045, Chapel Hill, NC, 27599-7045
- I may refuse to sign this Authorization:
  - The University of North Carolina at Chapel Hill, School of Medicine, Office of Information Systems, will not condition my treatment, any payment, enrollment or eligibility of services for benefits on receiving my signature on this Authorization

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. **It is possible that once disclosed, the privacy of this information may no longer be protected by federal and state privacy and security laws.**

Unless revoked according to the above directions, this authorization will not expire.

I have read and understand the information in this Authorization form.

Signature of Individual: *if over 18 years of age*	
Printed Name:	Date:

-OR-

Signature of Authorized Representative:	
Printed Name:	Date:
Please explain Representative's relationship to the individual:	
If the child is a minor between the ages of 12 and 18 and has the appropriate comprehension to provide assent to this authorization, they also should sign their name below.	
Signature of Minor 12 – 18 years of age:	

Witness: _____ Date: _____

Printed Name and Title: _____