University of Iowa Health Care Photo Consent Form

ADMIN AUTHORIZATION FOR RELEASE OF INFORMATION AND/OR USE OF PHOTOGRAPH, VIDEO, AND AUDIO

To be completed before student attends educational program or tour. This completed form must be scanned into the student's record.

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Student Name (please print) **Student Birth Date**

_____

Address **City** **State** **Zip Code**

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Home/Work/Cell Phone **Email**

I agree to allow the University of Iowa Health Care to interview, photograph, video monitor, video record, and audio record me (or the student named above for whom I give this permission) for the following purpose(s) marked below:

- ❑ Promotional uses that may include identifying information alongside my name, my image, my likeness, and/or my spoken or written comments. I understand that these promotional uses may include feature stories, advertisements, videos, or other formats that will appear in public media.

- ❑ Educational or operational uses in an academic setting or publication, including but not limited to, a professional conference or journal, or a hospital guided tour. I understand that photographs and/or audio/video recordings may be a part of my student record. Captured photographs and/or audio/video recordings will include only the minimum and relevant content necessary to satisfy the specified and authorized purpose.

- ❑ I agree to allow the University of Iowa Health Care to use my name, comments, and/or image for up to six (6) years without additional approval. I understand that my visit experience will not be impacted if I do not sign this form.

- ❑ I understand that once this information is disclosed, it may no longer be protected by federal privacy regulations. I understand that this authorization is voluntary and that I may revoke this authorization at any time by providing written notice to the following address: STEM-Education@uiowa.edu or UIHC-HSSB, STEM Education, Suite 206, 3281 Ridgeway Drive, Coralville, IA 52241. I understand that if I revoke this authorization, it will not affect any actions taken by UI Health Care prior to receiving my written notification. I understand that I may call 319-335-0215 with any questions I have regarding this authorization

_____

Signature of visitor or visitor parental guardian (for visitors under 18) Date

_____

Printed Name of visitor or visitor parental guardian (for visitors under 18) Relationship to Visitor

Please return this form to University of Iowa Health Care STEM Education Programs: UIHC-HSSB, STEM Education, Suite 206, 3281 Ridgeway Drive, Coralville, IA 52241.