University of Nebraska Medical Center
Nebraska Medicine

MEDIA AUTHORIZATION FORM

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Description of Information to be released:

Photo to be used in book on MMI Institute, "A Century of Caring"

Reporter/Affiliation: John Keenan/MMI Possible air/publication date: TBD

Consent to: ☑ interview ☑ photography ☐ videotape ☐ other

In the interest of education and advancement of the health sciences, I, the undersigned, voluntarily authorize Nebraska Medicine/University of Nebraska Medical Center (Hospital/UNMC) and its employees and agents to take photographs, produce newspaper or magazine articles, television programs, videotape recordings, internet materials and other visual and/or audio recordings in which I may be included in whole or in part for showing to the general public for publicity and promotion. I have had the opportunity to ask questions about the potential uses of the interview/photograph/videotape or other audiovisual.

☑ I consent to having my name identified with the materials. ☐ I prefer not to be identified by name.

I grant this authorization and give my consent as a voluntary contribution to the advancement of medical and other health sciences and education. Therefore, I waive the following: (1) any proprietary rights in the materials, and (2) any rights I may have to inspect or approve the finished materials prior to publication.

I understand that the entities that receive the information may not be covered by federal privacy regulations, and that the information described above may be used again by the recipient.

I understand that Hospital/UNMC ☐ will/ ☑ will not receive compensation for its use/disclosure of the information.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment (if applicable).

I understand that I may withdraw this authorization in writing at any time by notifying John Keenan 402-559-8329
(staff name/phone)

I understand that Hospital/UNMC may not be able to honor my request to withdraw this authorization if the information has already been released.

I release Nebraska Medicine/University of Nebraska Medical Center and its employees and agents from any claims arising from the use of such materials.

_____ _____
Signature of Individual Signature of parent, guardian, or authorized Representative

_____ _____
Date Relationship of above person to individual

X
_____
Witness