Media Authorization Form

I authorize The University of Texas Health Science Center at Houston ("UTHealth") or its agents or affiliates to obtain, retain and/or release, in its sole discretion, any and all Media Images of me (or my child), which may also contain information and/or materials concerning my (or my child's) condition or treatment for the purposes of publicizing, promoting, marketing, or advertising UTHealth's activities, programs, and services. For purposes of this Authorization, Media Images includes my (or my child's) image or likeness on photo, videotape and digital media, including, but not limited to audio/video interviews, photographs, and/or illustrations. I further understand that my name (or my child's) may be used in connection with these Media Images unless I have specifically restricted the use of my name (or my child's) below. I understand that the Media Images may include Protected Health Information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA), that may, at UTHealth's sole discretion, be utilized in publications and or productions of UTHealth's own making and distribution, and may be disclosed to or used by news media, including professional medical or healthcare journals, for publication, and/or broadcast, and/or distribution online or via other means to the general public, not excluding use at professional meetings, symposiums, poster sessions or other events. I acknowledge and understand that UTHealth has no control over or responsibility for the use of such Media Images once released. These Media Images may be used in whole or part as long as this authorization is in effect and UTHealth has not received notice that this authorization has been revoked. I also understand that I am not required by UTHealth to execute this authorization, and that such authorization is not a condition of receiving health care. I understand I have a right to refuse to sign this authorization. My health care (or my child's) and the payment for my health care (or my child's) will not be affected if I do not sign this form.

Person(s)/ Organizations at UTHealth providing the information: **Dr. Dianna M. Milewicz**

The information may be disclosed to and used by the **Montalcino Aortic Consortium.**

Information to be disclosed: **photo, videotape and digital media**

Other: _____

I understand that I may be identified by name in connection with the release and/or use of Media Images and/or information and material(s) contained therein. **I restrict the use of my name by signing here:** _____

I understand that this authorization is voluntary and can be revoked at any time. I understand that Media Images and/or the information contained therein may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information. I understand that UTHealth received no direct or indirect remuneration as a result of this authorization.

This authorization expires on *six (6)* years after the end of the study.

I understand that expiration of this authorization will not cause or require the Media Images, or the information and/or materials contained therein utilized or released as a result of this authorization to be withdrawn from use and/or circulation at the time of the expiration or this authorization or any time thereafter.

_____
Printed Name of Subject

_____ _____
Signature of subject or subject's legal representative **Date**

_____
Address **City** **State** **Zip Code** **Telephone**

_____
Printed Name of Person Obtaining Consent

_____ _____
Signature of person obtaining consent **Date**

UTHealth
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