



UT Medical Group, Inc.

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Authorization To Photograph And Publish

Name: _____
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Address _____ Date of Birth: _____
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1. I authorize UT Medical Group, Inc. ("UTMG"), its officers, agents, and employees to take photographs of me, to interview me, to publish, print and broadcast my voice and image for public relations and news media purposes (including, but not limited to, newspapers, web, or news television programs) and for educational, medical, scientific or research purposes.
2. I understand that my identity may be revealed through the use of my photographs and/or through the use of my name and voice.
3. Photographs shall remain the property of UTMG. I understand that, unless an action has already been taken in reliance on this Authorization, I may revoke this Authorization by written notice delivered to the UTMG Marketing Department at any time.
4. UTMG, its officers, agents, and employees are released from any legal responsibility or liability for disclosure of the information referenced above to the extent indicated above.

Signature of Patient or Personal Representative*

Printed Name of Patient or Personal Representative*

Date

*Relationship to Patient (if Personal Representative)

*If Personal Representative, the patient is unable to sign because (check one):

Minor Incompetent Other (explain): _____

=====**For Office Use Only**=====

Date received (please print): _____

Received by (*employee name*): _____ Title: _____