

Photography/Audio/Video/Personal Information Patient Release and Authorization Form

Printed name(s): \_\_\_\_\_

By signing and dating this form, I affirm that I have carefully read the following information and give the University of North Carolina at Chapel Hill Adams School of Dentistry (UNC ASOD) the following permissions:

I, \_\_\_\_\_ (printed name), give my permission to be photographed/videotaped and/or interviewed by external news media and/or by UNC ASOD /University of North Carolina at Chapel Hill (University) personnel about care I have received or am receiving at one of the UNC ASOD clinics. I understand HIPAA will no longer apply and that my name, image, condition/reason for treatment and other protected patient information may be used in these communications. **“External news media” means that these people are not employees, or under the control, of the UNC ASOD or the University. They may work for newspapers, magazines, television or radio stations, or other electronic media (websites), for example. This permission also extends to the care provided outside the UNC ASOD by students, faculty and/or staff of the school.**

Furthermore, I also give my permission for these photographs, videos and/or comments to be incorporated within the communications about the UNC ASOD, the University and its programs to the public without compensation to me. These purposes could **include publications through the school’s website, social media outlets** (e.g., Facebook, YouTube), PowerPoint presentations, the *North Carolina Dental Review* (**the school’s magazine**), **academic catalogs, informational** videos and assorted print documents, among other communications. Additional purposes also could include academic presentations, communications external to the UNC ASOD, such as by television, radio, newspaper, magazines, periodicals, journals and other media – as well as the web presences of any relevant media.

I acknowledge that the approval I give to be photographed, videotaped and/or interviewed is to the media representative and to the UNC ASOD. I understand that I may be identified by name in printed, broadcast, radio or online communications. I further understand that such information may be re-published in the same or additional format (e.g., using a story that first appeared in a newspaper later in a magazine about the UNC ASOD or vice versa). The original information could also be provided by the media representative to the UNC ASOD and its programs to the public without compensation to me.

I hereby release and forever discharge the University, its agents, officers and employees from any and all claims and demands arising out of or in connection with the use of said photographic, audio or video images and information, including but not limited to, any claims for invasion of privacy, appropriation of likeness or defamation. I agree that all pictures, photographs, video and audio recordings and any reproductions thereof, and all plates, negatives, recording tape and digital files as described herein shall remain the property of UNC ASOD and/or the external news media. I waive the right to approve the final product(s) and understand that neither the media representative nor the UNC ASOD is obligated to provide the image, videotape or audiotape to me. This release and authorization is binding on me, my heirs, legal representatives and assigns, and does not have a termination (end) date.

I understand that it is my right not to sign this form, and that this decision will not, in any way, affect my treatment relationship with the UNC ASOD.

Check whichever applies:

\_\_\_\_ I hereby affirm that I am at least 18 years old and competent to contract in my own name, or

\_\_\_\_ I am acting on behalf of \_\_\_\_\_ and affirm that I am the guardian or legal representative of such individual.

\_\_\_\_\_  
Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date