UF UNIVERSITY of FLORIDA

AUTHORIZATION to Use or Disclose De-identified Health Information for Publication and Educational Purposes

Patient's Name [redacted]	Verification of Identity (Driver's License, ID Card, Passport, etc.)	
Patient's Address [redacted]		Date of Birth 2/27/1976
Phone # [redacted]	Phone #	Email Address [redacted]

**** Complete the following only if the person authorizing the use or disclosure is not the patient:***

Name	Relationship to Patient	Verification of Identity	Verification of Authority
Representative's Address	Phone #:	E-mail Address:	

See the UF Policy for Verification of Identity and Authority and Personal Representatives in the Operational Guidelines.

By signing this form, I authorize the following: De-identified health information about me / the patient, described below and held by ***The University of Florida,*** may be used or disclosed **from** records about my care and treatment provided by:

(College, Department, Clinic, Physician, or Other Person)

Specify: UF Health department of Anesthesia, ENT, Opthalmology, ICU

My / the patient's de-identified information may be **used by** or **disclosed to**:

- ☐ The General Public via print, radio, television, Internet, or other methods.
- ☑ A specific entity, group, or person only (*Specify):* Medical Journal

Address, if known:	Contact/Responsible Party:	Phone / Email/ Other Contact

The following health information may be disclosed: (*Check all that apply)*

- ☑ Video recorded during a procedure, surgery, or other health care encounter
- ☑ Photographs taken during a procedure, surgery, or other health care encounter
- ☑ Other images recorded during a procedure, surgery, or other health care encounter

*(describe)*_____

No identifiable information (name, address, record or identifying numbers, etc.) or images (face or other uniquely identifiable body features) will be included with or in the videos, photographs, images or any related health data.

This health information will be used or disclosed only for educational purposes, which may include publication in books or journals, or classroom instruction and/or medical training at the University of Florida, other educational institutions, and/or national and international conferences.

- I understand that, by federal law, UF may not use or disclose protected health information (PHI) without authorization except as provided in UF's Notice of Privacy Practices. By signing this Authorization, I am giving permission for the use or disclosure of the information described above for the purpose(s) described. I hereby release the University of Florida and its employees from any and all liability that may arise from the release of information as I have directed. I have the right to receive a copy of this form and the health information released.
- I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this authorization.
- I understand that I may refuse to sign this Authorization, and that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.
- I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal health information privacy law and could be re-disclosed by the person or agency that receives it.

* [redacted] *Please place Initials)* I agree that this authorization will remain in effect until I revoke it in writing.

Signature of Patient or Legal Representative: [redacted]	Date 8/16/21

Complete all parts of the form, print out and sign and date. Patient or representative should keep a copy. Give, fax, email, or mail the original form to the person or organization releasing the information.