

**AUTHORIZATION FOR RECORDING**

**for**

**CLINICAL EDUCATION PURPOSES**

1. **Release of Information to University of Massachusetts Medical School**

I hereby authorize the University of Massachusetts Medical School (UMMS) to photograph and/or interview me, use my writings, record my sound, voice, and/or image (“Recordings”) for clinical education purposes. I understand that the Recordings will be shared with the clinical education staff and students at UMMS and the Recordings will not become public. The Recordings will only be used for clinical education purposes.

1. **Ownership**

I understand that the Recordings become the property of UMMS and that they may be used as deemed appropriate by UMMS for clinical education purposes and in such forms as print, photographs, slides, movies, audio and/or videotapes.

1. **License**

I grant to UMMS and others acting on its behalf:

a. a perpetual, irrevocable, royalty-free nonexclusive worldwide license to use the Recordings for clinical educational purposes; and

b. the right and permission to record, copy, reproduce, adapt, edit, summarize, distribute and otherwise use by any and all means, the Recordings in any format whatsoever. This grant includes, without limitation, the right for UMMS to use the Recordings in any clinical educational video, film or program, whether in print, electronic, photo or essay format.

1. **Miscellaneous**
2. I understand that no fees will be paid to me for the use of the Recordings.
3. I understand that this consent is voluntary and that treatment, payment, enrollment or eligibility for benefits are not conditioned on providing my consent.
4. I waive any right to inspect or approve Recordings or the use to which such Recordings may be applied.
5. I release, discharge, and hold harmless UMMS and its employees, officers, directors and agents from liabilities and all claims and expenses arising from or in connection with the Recordings, my participation, and the use of the Recordings.
6. I understand that UMMS will safeguard the Recordings but once the Recordings are shared with the clinical staff and students at UMMS, there is a potential that the information may be re-disclosed and no longer protected by HIPAA.
7. I understand that nothing herein constitutes any obligation on UMMS to make any use of the Recordings.
8. I understand that I may revoke this consent in writing at any time by contacting the UMMS Senior Director of Compliance and Privacy at privacyandcompliance@umassmed.edu. However, once UMMS relies on this Authorization to create the Recordings, I will no longer be able to withdraw my permission.
9. This Authorization expires 6 months from the date the Authorization is signed.

My signature below acknowledges that I understand and agree to give permission for UMMS to create the Recordings and use them for clinical education purposes as stated herein.

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Signature of Individual Date

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Print name

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Signature of UMMS Witness Date

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Print Witness’s name