AMERICAN COLLEGE of RHEUMATOLOGY
Empowering Rheumatology Professionals

PATIENT AUTHORIZATION AND RELEASE FORM

I consent and agree that the photograph(s), or medical image(s) made of me on_____(date) by _____ (physician's name) may be distributed to and used by the American College of Rheumatology ("ACR") or its licensees or assigns for the purposes of public information, public education, training, and for any other purposes ACR deems appropriate to inform the medical profession or the general public about the field of rheumatology.

I have been advised that neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photograph(s) may portray features that will make my identity recognizable.

I grant this consent as a voluntary contribution in the interest of public education. I understand that such photograph(s), or medical image(s) shall become the property of ACR and may be shown, published, printed, broadcast or otherwise disseminated in any print, visual or electronic media, specifically including, but not limited to, via websites, Internet Web casts, newspapers, television, medical journals and textbooks. I release and discharge Dr._____, ACR and all parties acting under their license and authority from all rights that I may have in the photograph(s), or medical image(s), including any claim for payment in connection with their distribution or publication.

I understand that, to the extent permitted by law, I have the right to inspect and copy the photograph(s), or medical image(s) that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If I do not revoke this authorization, it will expire ten years from the date of its execution.

I understand that the photograph(s), or medical image(s) disclosed, or some portion thereof, may be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ACR is not receiving the photograph(s), or medical image(s) in the capacity of a health care provider or health plan covered by HIPAA, the photograph(s) or medical image(s) may be re-disclosed and may no longer be protected by HIPAA.

By signing this form, I certify that I have read the above authorization and release and fully understand its terms.

Patient Name: _____

Address: _____

City:_____State:_____Zip:_____Country: _____

Signature:_____Date: _____

If patient is a minor:

Guardian Name: _____

Address: _____

City:_____State:_____Zip:_____Country: _____

Signature:_____Date: _____