University of Miami

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION AND PHOTOGRAPHS FOR PUBLICATION

DONOR FAMILY NAME: _____ **SOCIAL SECURITY:** _____

ADDRESS: _____ **PHONE NUMBER:** _____

_____

I, _____, have read the attached article, approve its content, and authorize the

publishing of my loved one's medical information provided therein by the _____, a publication of
(insert name of Publication)
the University of Miami School of Medicine. (Attach copy to authorization form – Attachment 46).

I further authorize the taking and use of the attached photograph(s) and/or likeness specifically attached, to be published in the

_____magazine.
(insert Name of Publication)

_____	_____	_____
SIGNED	**WITNESSED BY**	**DATE**
_____	_____	_____
PRINT NAME	**PRINT NAME**	**DATE**

_____ _____

SUBJECT'S REPRESENTATIVE/Relation to Subject **SUBJECT'S DATE OF BIRTH**

(if subject is under 18 years of age and/or if subject was an organ/tissue donor)

(For identification purposes, describe project and images)

_____

_____

Patient Name: _____
IDX #: _____
Patient SS#: _____
Department Name: _____