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 Advanced Academic Rheumatology Review Course (hereafter ADARRC) or its licensees or assigns for the purposes of public information, public education, training, and for any other purposes that 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 case.

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

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

Patient Name: _____

Contact Information: _____

Signature: _____ Date: _____

If patient is a minor: _____

Guardian Name: _____

Contact Information: _____

Signature: _____ Date: _____