Reset Form

MAYO CLINIC

Authorization for Media Release – Photograph, Video, or Interview

This form collects information that is not part of the medical record. **For local storage only.**

Story Name	Publication Date *(Month DD, YYYY)*
Physician Name	Public Affairs Staff

I authorize Mayo Clinic to disclose the name and contact information of

Patient Name_____ Birth Date _____
(Month DD, YYYY)

Mayo Clinic Number _____

and to disclose details of the following medical conditions _____

_____

("Medical Conditions") to media representatives selected by Mayo Clinic ("Media Representatives"), or through interviews, photographs, audiotapes, and/or films (including digital media) ("Materials") for public dissemination by Mayo or media. The purpose of this disclosure is to allow Media Representatives to record Materials, and for Mayo to disseminate health information to the general public. I also authorize Mayo personnel, including the Patient's treating physician, to be interviewed by Media Representatives (or Mayo) and to discuss details of the Patient's Medical Conditions.

I agree that any Materials taken shall be the sole and exclusive property of Mayo or Media Representatives, and that they may use the Materials in any manner they wish, including dissemination to the general public via any media. I also understand that the name and/or identity of Patient may also be used for these purposes.

I understand that this authorization may be revoked at any time except to the extent action has been taken in reliance upon it. Furthermore, I understand that this authorization will remain in effect unless specifically revoked by me. Revocation must be made in writing to Mayo Clinic, Department of Public Affairs, 200 First Street SW, Rochester, MN 55905.

I authorize the above without expecting payment, and I release Mayo Clinic and its employees from any and all liabilities which may arise from the use of Materials. Mayo Clinic will not condition treatment on whether I sign this authorization.

Furthermore, I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

I understand that a copy of this authorization will be provided to me when Mayo Clinic receives the authorization.

Signature Signature Required	Date *(Month DD, YYYY)*		
Relationship to Patient *(if not patient)*	Daytime Phone		
Mailing Address	City	State	ZIP Code
Email			

Part 1 - (white original) Public Affairs (return to CE-9) • Part 2 - (yellow copy) Patient

Print