***Journal of the American Academy of Dermatology***

**HIPAA Authorization to Disclose Protected Health Information**

I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Medical Institution/Physician) to take pictures, videos, or any other form of recording of my likeness and disclose this information along with protected health information about me, including treatment information and diagnoses, to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Author) and the American Academy of Dermatology’s *Journal of the American Academy of Dermatology,* its subsidiaries, and any related organizations (“*JAAD*”) to use and disclose for publication in *JAAD*, and additionally for materials for teaching, research, scientific meetings, other professional journals, medical books, broadcasts, advertising, and other purposes.

The information may also be disclosed to external media in the form of journal case reports and posting and discussion on social media pages. It may also be used for internal purposes, on the *JAAD* website or through *JAAD*’s own educational campaigns. I understand this information **will not** include my name without further authorization by me. If all information that does or can identify me is removed from my health information, the remaining information will no longer be subject to this authorization and may be used or disclosed for other purposes.

I understand the provision of health care treatment, payment for my health care and my health care benefits are not dependent on this authorization (when the Covered Entity is not providing treatment solely for the purpose of creating protected health information to disclose to *JAAD*). I understand I am not required to sign this authorization; however the information will not be used or disclosed without authorization. I understand any information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand I have the right to revoke this authorization in writing, except to the extent information has already been released pursuant to this authorization at the time of the revocation. I can revoke this authorization by writing to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Medical Institution/Physician).

I hereby release, discharge and agree to hold the *Journal of the American Academy of Dermatology* and its officers, directors, employees, agents, and representatives harmless from any liability that may arise from the release of information authorized above.

The rights granted herein may be exercised by the *Journal of the American Academy of Dermatology* at any time hereafter for perpetuity, without limitation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature and printed name of patient/individual

OR: If the patient/individual is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the patient/individual named above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature & printed name of guardian

Relationship to patient/individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

***Journal of the American Academy of Dermatology***

**Consent for Publication of Photos, Videos, and Other Identifying Materials**

I hereby consent to publication in the American Academy of Dermatology’s *Journal of the American Academy of Dermatology (“*JAAD*”)* ofphotographs, other images, video tapes, sound recordings, or other materials that may identify my child or me (“the Materials”). I understand that the *Journal of the American Academy of Dermatology* will own the copyright to these materials and may grant permission for use of these materials for teaching, research, scientific meetings, other professional journals, medical books, broadcasts, advertising, and other similar purposes. These materials may appear in print and online and the public may have access to them. I understand that I will not be entitled to any compensation for *JAAD*’s use of the Materials.

I understand I have the right to revoke this authorization in writing, except to the extent information has already been released pursuant to this authorization at the time of the revocation. I can revoke this authorization by writing to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Medical Institution/Physician).

I hereby waive any claim, cause of actions, damages, or loss (including attorney’s fees) that I may have against the *Journal of the American Academy of Dermatology* or its officers, directors, employees, agents, and representatives with respect to the use of photographs, video tapes, sound recordings, or other materials that may identify my child or me as agreed to in this document, including without limitation any claims based on libel, slander, or the rights of publicity, privacy or personality.

The rights granted herein may be exercised by the *Journal of the American Academy of Dermatology* at any time hereafter for perpetuity, without limitation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature and printed name of patient/individual

OR: If the patient/individual is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the patient/individual named above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature & printed name of guardian

Relationship to patient/individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date