Shirley Ryan AbilityLab

**Consent to Disclose Patient Information, Photograph/Record a Patient, and Share Images**

Patient's First and Last Name ("Patient") Medical Record # (where applicable)

Phone Number E-mail Address

I permit the Shirley Ryan AbilityLab, its affiliates, contractors, vendors, and agents ("SRAlab") to disclose the name or other identifying information about the Patient named above. I also permit SRAlab to take, use, and release photographs, video, other recordings ("Images") of the Patient named above. The Images may be taken, reproduced, displayed, disclosed, used, published, or released ("Used" or "Use") in the interest of medical science, research, education, donor relations, fundraising or general public relations for SRAlab, or any such other related purposes as SRAlab decides is appropriate, without limitation as to the time or date of Use. Such Use includes, but is not limited to, making the Images available in any articles, marketing materials, news releases, annual reports, internal and external publications (including media outlets), external websites, award competitions, broadcast programming, and/or website postings, including postings to social media websites such as Facebook, Twitter, or Instagram.

In addition to the Patient's name or other identifying information, SRAlab may Use the Patient's health information, medical condition, and medical or professional treatment, as it deems appropriate, in connection with the Images and/or for the purposes set forth in this consent. The Use may be in writing, by e-mail or other electronic method, or in another manner. I can ask to inspect a copy of the Patient health information released under this consent.

By signing below, I understand that I am providing formal written consent to SRAlab as set out above. This consent lasts forever, but I can take it back ("revoke it") in writing. I can ask Shirley Ryan AbilityLab to stop taking Images, or I can revoke this consent, by requesting it within a reasonable amount of time prior to Use of the Images. I will send any such request in writing to Privacy Officer, Shirley Ryan AbilityLab, 355 E. Erie Street, Chicago, Illinois 60611 or by e-mail to privacyofficer@sralab.org. If SRAlab has already used or released the Images, my revocation will only be valid for future use of the Images by SRAlab. I understand that SRAlab cannot control how third parties use the released Images.

I understand I am not required to sign this consent, and that SRAlab will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign it. I understand that health information disclosed under this consent may be re-disclosed by the recipient to others who may not be required to protect it under HIPAA or other applicable law. I acknowledge that I am entitled to receive a copy of this form upon request.

Signature of Patient or Legally Authorized Representative Date
(If legally authorized representative, also state relationship to Patient)

***ORIGINAL*** *- to Shirley Ryan AbilityLab File* ***COPY*** *– to Patient/Legally Authorized Representative Upon Request*