

MEDIA AUTHORIZATION FORM

Name: David McClure

Address: 1212 Prairie Ave City: Bellevue State: NE ZIP: 68005

Description of Information to be released:

Details related to anesthesia and post-operative care from ~~my~~ surgery in March 2019

Reporter/Affiliation: _____ Possible air/publication date: _____

Consent to: interview photography videotape other

I authorize Nebraska Medicine/University of Nebraska Medical Center (Hospital/UNMC) and its employees and agents to disclose/publish to the public my information, image, likeness, voice, and comments as relevant to the box(es) selected above. I understand my voluntary participation in this media campaign may reveal information on my condition or the medical/behavioral services I received from Hospital/UNMC. I understand this information may be used by Hospital/UNMC in connection with advertising, publicity, promotion or other media purposes, which could include producing newspaper or magazine articles, television programs, videotape recordings, internet materials and other visual and/or audio recordings.

I authorize having my name identified with the materials. I prefer not to be identified by name.

I understand I do not have any proprietary rights in the materials produced or any rights to inspect or approve the finished materials prior to publication or the use to which it may be applied. I have had the opportunity to ask questions about the potential uses of the interview/photograph/videotape or other materials to be produced.

I understand that once disclosed publicly the information may be redisclosed or used by the public and no longer be protected by state and federal law.

I understand that Hospital/UNMC will/ will not receive compensation for its use/disclosure of the information.

This authorization shall expire only in the event that I withdraw my authorization. I understand that I may withdraw this authorization in writing at any time by notifying the Privacy Office in writing at 988102 Nebraska Medical Center, Omaha NE 68198-8102 or by calling toll free at 1-800-552-8802, Ext. 9-5136. I understand that Hospital/UNMC may not be able to honor my request to withdraw this authorization if Hospital/UNMC has already acted in reliance on my authorization.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment (if applicable).

Phone Consent: 402-880-5013 (cell)
Signature of Individual

Tanner Ghaly
Signature of parent, guardian, or authorized Representative

6/25/2021
Date

Relationship of above person to individual

Rebecca Aeon MD
Witness

