Physician Assistant Program
School of Medicine

Student Authorization for Release or Publication of Educational Information

The PA Program requires your authorization to share program-specific information regarding the following items. Your authorization gives the program permission to share the information, on an as needed/as requested basis, for program purposes only. Please be aware the program will not share any personal information unless it is required to facilitate your education during the academic and clinical years of the program.

Notwithstanding any requests to restrict OHSU Directory Information that I will submit separately to the OHSU Registrar's Office, I _____, authorize the OHSU Physician Assistant program to release or publish the specific items listed below:

1. Name, home address, e-mail address(s), phone number(s) and photos to currently enrolled OHSU PA Program students and faculty, for the purposes of facilitating communication amongst students prior to and during matriculation. *Initials:* _____

2. On a very limited basis, for specific purposes only, name, home address, e-mail address(s), phone number(s), social security number, date of birth, curriculum vitae, and photos to mentors, preceptors, clinics, hospitals, and other agencies which may require some or all of these items for clinical experiences. *Initials:* _____

3. Name, home address, e-mail address(s), phone number(s), automobile license number to clinical year housing contacts which may require some or all of these items for program-provided housing for clinical rotations. *Initials:* _____

4. Name, home address, date of birth, enrollment date, anticipated graduation date, and OHSU e-mail address to the American Academy of Physician Assistants (AAPA), Division of Data Services & Statistics, the Physician Assistant Education Association (PAEA), and/or the National Commission on Certification of Physician Assistants (NCCPA). *Initials:* _____

5. Provide authorization to the American Academy of Physician Assistants (AAPA) to request that I be subscribed to the Journal of the American Academy of Physician Assistants (JAAPA) and receive other appropriate professional information from the AAPA or other organizations working on behalf of the AAPA. *Initials:* _____

I hereby authorize OHSU and their respective officers, directors, employees, agents and contractors acting on its behalf, to use my image and likeness in any form of media, including still image photograph, voice audio, and/or video image, and to offer those images and/or recordings for use or distribution for the Purposes identified above without notifying me. I authorize OHSU and Entity to use my name in connection with the images and/or recordings and to use, copy, reproduce, exhibit or distribute in any medium (e.g. print publications, digital, video, CD-ROM, Internet/WWW) those images and/or recordings. Neither OHSU nor Entity is required to use any image and/or recording obtained and may discontinue using such images and/or recordings at any time.

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I understand that all negatives, prints, digital reproductions, recordings, and videotapes shall be the property of OHSU and shall not be returned to me. I waive any rights, title, claims or interest I may have to control or approve of the use of my identity of likeness in the photographs, publications, or media (printed or electronic) or other use of the images and/or recordings now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the images and/or recordings. I hereby agree to release and hold harmless OHSU and Entity, including their respective officers, directors, employees, and contractors from and against any claims, damages or liability arising from or related to the use of the images and/or recordings, including but not limited to any re-use, distortion, blurring, alteration, optical illusion or use in composite form, either intentionally or otherwise, that may occur or be produced in production of the finished product. I agree to release OHSU and those acting pursuant to their respective authority from liability for any violation of any personal or proprietary right I may have in connection with any use of my likeness or image for any use described above.

I understand I may revoke this authorization at any time with a written request from me, including signature, delivered to the Division Administrator, Physician Assistant Program. Revocation of this authorization will not apply to information released or published prior to the receipt of the written revocation request.

_____ _____

Student Signature (typed name as signature is acceptable) Date