AUTHORIZATION AND CONSENT
RECORDINGS, FILMS OR OTHER IMAGES, AND PUBLICATION

The undersigned hereby authorizes _____ Hospital and the attending physician to record, film or take other images or permit other persons to record, film or take other images of _____ (patient's name) while under the care of the above named hospital. The undersigned agrees that the above named hospital and the attending physician may use and permit other persons to use the negatives or prints prepared from such recordings/films/other images for such purposes and in such manner as either may deem appropriate. The undersigned agrees the recordings/films/other images may be used for purposes including, but not limited to, dissemination to hospital staff, physicians, health professionals and members of the public for educational, treatment, research, scientific, public relations and charitable purposes. This recording/film/other image is intended for the following circumstances:

_____

_____

_____

Dissemination of the recording/film/other image may be accomplished in any manner and that such use is subject only to the following limitations:

_____

_____

_____

The undersigned has entered into this agreement in order to assist scientific treatment, educational, public relations and charitable goals and hereby waives any right to compensations for such uses by reasons of the foregoing authorization, and the undersigned and his/her successors or assignees hereby hold the above named hospital and the attending physician and their successors and assignees harmless from any or against any claim for injury or compensation resulting from the activities authorized by this agreement.

The undersigned understands that he/she has the right to rescind consent before the recordings, films or other images are used.

Recordings, films or other images are defined as photographic, video, electronic or audio media, and any other mechanical means of recording and reproducing images or voice.

Date: _____ Time: _____ AM/PM Signature: _____
Patient/Parent/Conservator/Guardian

_____ _____
Signature of Witness If signed by other than patient, indicate relationship

Original to patient medical record

Copy to patient/patient representative