Patient Name: _________________________________ DOB:____________________

## CONSENT TO PHOTOGRAPH / VIDEOTAPE / TELEVISE / BROADCAST

TO THE PATIENT: You have the right, as a patient, to privacy and confidentiality during your hospitalization. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the proposed photograph and/or videotaping and/or televising and/or broadcasting.

REQUESTED MEDIA: I (we) understand that the following photograph and/or videotape and/or televise/broadcast has been planned for me and I (we) voluntarily consent and authorize this release of my image and other confidential medical information that is conveyed through my image and the media (patient should initial all that apply):

_____ Photograph

_____ Videotape

_____ Photograph and Videotape

_____ Photograph and Videotape with Interview

_____ Photograph and Videotape during a Procedure or Surgery

_____ Televise/Broadcast during a Procedure or Surgery

PURPOSE(S) FOR PHOTOGRAPHY/VIDEOTAPE/TELEVISE/BROADCAST:

______________________________________________________________________________

______________________________________________________________________________

INFORMED CONSENT: I agree that the Hospital or my doctor or other organization may use or permit other persons to use the negatives or prints prepared from the photographs and/or my words or written materials reflecting my interview and/or the videotape images for any purposes and in such manner as they may choose including, but not limited to, use in informational and/or promotional materials about the Hospital. In the event photographs/videotapes are required by the police/prosecutors, I (we) hereby authorize the photographing, videotaping, televise, broadcast of me and/or my procedures.

I understand that I have the right, except in circumstances where photograph/videotape are required by the police or prosecutors, to request that the recording be stopped and to rescind my consent for use up until a reasonable time before the recording or film is used.

I understand that I will not be compensated or reimbursed in any way for current or future use of my likeness, words or ideas.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in and I (we) understand its contents.

**THIS IS A LEGAL CONSENT FORM. PLEASE READ IT CAREFULLY AND BE SURE YOUR QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING.**

______________________________ Date: _____________ Time: _________a.m./p.m.
Signature of Patient or Legal Representative

______________________________ ______________________________
Legal Representative's Relationship to Patient Witness Signature Witness Name (Print)

______________________________
Address if not Hospital Employee: Address

______________________________

**NOTE: THIS CONSENT SHOULD NOT BE USED FOR RESEARCH RELATED PHOTOGRAPHING, VIDEOTAPING, TELEVISING OR BROADCASTING.**

**HOSPITAL NAME MUST BE FILLED IN BLANK BELOW**

PATIENT IDENTIFICATION

*ADMCON*

**CONSENT TO PHOTOGRAPH / VIDEOTAPE / TELEVISE / BROADCAST**