

PID

Consent to Photograph

I authorize [**ORGANIZATION**] to photograph/videotape/interview me and to use such photographs/videotapes/comments in any publications (including, but not limited to newspapers, television, radio, magazines, newsletters, and marketing materials) in such manner and at such times and in such places as described below, without restriction unless otherwise noted:

- | | Yes | No |
|--|-------|-------|
| 1. To use such photographs, videotapes, or comments for external scientific and educational purposes only. | _____ | _____ |
| 2. To use any quotations and comments concerning the below named patient's medical case. | _____ | _____ |
| 3. To use such photographs, videotape, or comments in connection with any external publication or broadcast and <u>include</u> the patient's name. | _____ | _____ |
| 4. To use such photographs, videotape, or comments in connection with any external publication or broadcast <u>without</u> including the patient's name. | _____ | _____ |

Restrictions: _____

Signature of Patient or Personal Representative

Relationship to Patient (if other than self)

Print Name

Date

Witness

You have the right to request to cancel this consent during recording or filming and up to a reasonable time before the recording or film is used. Treatment will not be conditioned upon whether you request to cancel your consent.

Topic: _____

Department using photo: _____

Representative name: _____

Consent valid from: _____ to _____
(date) (date)

Information disclosed pursuant to this consent to photograph may be re-disclosed by the recipient and may no longer be protected under the HIPAA Privacy Regulations.