Request and Consent to Photography and/or Video Record	NAME: MRN (REG #): BIRTHDATE:

Your provider may need to photograph and/or record you to document a medical condition, help with the diagnosis and/or treatment of a condition, and/or to help plan details of surgery. Photographs and/or recordings taken for these clinical reasons do not require your written permission. Your provider does need your written permission to use your photographs and/or video recordings for the non-clinical reasons below.

I hereby authorize the (Name of service, clinic, or department) _____, including the attending doctor or other designated person(s), to photograph and/or video record me for the following purposes: Check **YES** or **NO**.

	YES	NO
1. For the advancement of **not-for-profit** medical purposes, including teaching, research and education. I understand that education is an important part of the hospital's commitment to teaching younger healthcare providers.	☐	☐
2. To show or release to current or future _____ patients for the purpose of education and consultation. I understand these photos or videos can be taken at any time during my treatment which includes pre-treatment, post-treatment, pre-operative, intra-operative, post-operative photos, and/or videos of my treatment, surgery and/or procedure	☐	☐
3. For **external not-for-profit** educational purposes outside _____ such as lectures and presentations at professional conferences.	☐	☐

I consent to photographs and/or video recordings under the following conditions:

- Copies of the photos, videos, and/or films may be released to me if I ask for them,
- I can refuse to have photos and/or video taken without any change in my medical care at _____.
- I understand and agree that although my name will not be used, it may be possible to identify me from a photo and/or video and
- I understand that once released outside _____, _____does not have control over the photos or videos.

Revoking Permission: This authorization has no expiration date; but I may revoke it at any time by writing to _____ _____I must state in writing that I no longer give consent for photo(s) and/or video(s) or for the use of any photo(s) or video(s) that were already taken.

I have had enough time to discuss with my provider the information on this form. I have had the chance to ask questions and my questions have been answered. I have read and understand the information. I hereby release_____ its personnel, and any other persons participating in my care from any and all liability which may or could arise from the taking or authorized use of such photographs and/or video recordings.

_____ ____/____/_____
Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) Date (mm/dd/yyyy)

_____
Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)
Relationship ☐ Spouse ☐ Parent ☐ Next of Kin ☐ Legal Guardian ☐ DPOA for Healthcare

_____ ____/____/_____ _____ A.M./ P.M.
Consent Obtained, Explained and Witnessed By Date (mm/dd/yyyy) Time

TO PROVIDERS: Photographs and/or recordings taken for a clinical purpose do not require written consent. The photographs or video recording will be made part of the medical record. Written consent must be obtained prior to taking and/or using a photograph and/or recording for non-clinical purposes. If a photograph or recording is initially taken for a clinical purpose, and later deemed appropriate for a non-clinical purpose, written consent must be obtained prior to using the photograph or recording for the non-clinical purpose. For photography and/or video recording of patients related to *research*, please refer to the IRB website. For photography and/or video recording of patients for use in *promotional or marketing materials,* please use a form link, Permission to Release Information Including Photographs, Videos, Electronic or Other Media

		Original – Medical Record Copy – Patient / Family		Request and Consent to Photography and/or Video Record