**THIS IS A TEMPLATE. YOU WILL NEED TO EDIT TO MEET YOUR SPECIFIC NEEDS.**

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 conditions 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** |
| For the advancement of not-for-profit medical purposes, including teaching, research and education. I understand that education is an important part of XX’s commitment to teaching younger healthcare providers. | **⭖** | **⭖** |
| 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. | **⭖** | **⭖** |
| For **external not-for-profit** education purposes outside of this facility 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 be if i ask for them,
* I can refuse to have photos, and/or video taken without any change in my medical care at this facility,
* I understand and agree that although my name will not be used, it may be possible to identify me from a photo or video and
* I understand that once released outside of this facility, this facility 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 the XXXX  at the address below. I must state in writing that I no longer give consent for photo(s) and/or video(s) or 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 this facility, 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.

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

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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 recordings will be made part of the medical record. Written consent must be obtained prior to taking and/or using a photograph and/or video 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. Photography and/or video recording of patients for use in *promotional or marketing materials,* require a different consent form.