AUTHORIZATION for TAKING and USE OF PHOTOGRAPHS, MOTION PICTURES, VIDEO TAPES

I, _____________________________________________________________________, hereby authorize and/or ratify the taking of photographs, motion pictures or video tapes of the above named patient/person for Saint Francis Health System Public Information department, its affiliated hospital(s) or Warren Clinic offices, subject to the below listed conditions:

1. That the name of the patient/person and/or the patient's/person's family may not be used in any manner to identify the photographs, motion pictures, or video tapes.

2. That said photographs, motion pictures, or video tapes may be used for the purposes of: ☐ medical treatment; ☐ medical education; ☐ research; ☐ for publication if deemed necessary in the furtherance of medical research. The external recipients of the images and materials will or could be ☐ other patients, ☐ medical trainees, schools, researchers, publishers, persons or organizations within the medical industry, the media, general public and/or __________________________________.

3. That all photographs, motion pictures, or video tapes need not be shown to the undersigned prior to their publication and/or viewing.

4. That all prints and negatives of any type shall be the sole property of Saint Francis Health System, its affiliated hospital(s) or Warren Clinic offices. This designation is irrevocable.

5. That I have the right to request cessation of photographing, recording or filming.

6. That I have the right to rescind consent for use up until a reasonable time before the photograph, recording or film is used.

MEDICAL EDUCATION: I, _____________________________________________________________________, hereby authorize and/or ratify the taking of photographs, motion pictures or video tapes of all procedures and treatments of the above named patient in Saint Francis Health System affiliated hospital(s) or Warren Clinic offices, subject to the below listed conditions:

1. That the name of the patient/person and/or the patient's family may not be used in any manner to identify the photographs, motion pictures, or video tapes.

2. That said photographs, motion pictures, or video tapes may be used for the purposes of: ☐ medical treatment; ☐ medical education; ☐ research; ☐ for publication if deemed necessary in the furtherance of medical research. The external recipients of the images and materials will or could be ☐ other patients, ☐ medical trainees, schools, researchers, publishers, persons or organizations within the medical industry, the media, general public and/or __________________________________.

3. That all photographs, motion pictures, or video tapes need not be shown to the undersigned prior to their publication and/or viewing.

4. That all prints and negatives of any type shall be the sole property of Saint Francis Health System, its affiliated hospital(s) or Warren Clinic offices. This designation is irrevocable.

WAIVER of COMPENSATION: 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. This waiver is irrevocable.

RELEASE of LIABILITY: This consent is expressly intended to release from all liability of any nature the operating physician, attending physician, consultants of any nature and all agents and other personnel employed at Saint Francis Health System, its affiliated hospital(s) or Warren Clinic offices with regard to the taking, publishing or viewing of the photographs, motion pictures, and/or video tapes. This release is irrevocable. I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance on this Authorization, or to the extent that certain agreements are expressly irrevocable. This Authorization will expire in 12 months although certain agreements made irrevocable will continue to remain in effect.

WARNING: We have no control over any photographs, motion pictures or video tapes released to any person, firm or agency under this Authorization and it is therefore possible that a release of photographs, motion pictures or video tapes may occur by such party.

I UNDERSTAND THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED INFORMATION ABOUT COMMUNICABLE OR NONCOMMUNICABLE DISEASE, OR RELATED TO MENTAL HEALTH OR DRUG, SUBSTANCE OR ALCOHOL ABUSE.

TRANSLATION: This is to certify that the above Consent has been read to the patient (or representative) in his/her native language; all representations which appear in the Consent were understood and authorized by the patient (or representative).

INTERPRETER - SIGNATURE

WHITE - Chart  CANARY - Marketing  PINK - Department of Education