Final August 2011

Consent for Photographs (Pictures), Audio or Video Recording, Prepared Statements and Interviews

I give consent for use and/or release of my health information as described below.

I give consent for (check all that apply:)	**To do the following (check all that apply:)**
□ A representative of (list the hospital): _____	□ Take pictures of me.
□ A news company (list the company): _____	□ Record me on audiotape or videotape.
□ Other: _____	□ Work with me to make a personal statement.
	□ Interview me. This may include questions about my condition and care. I will have control over the health information I give out.
	□ Other:_____

For This Reason: _____

My pictures, video or audio recordings or statements may be used for newspapers, television, radio, magazines, booklets, the internet, or other uses. The use will be approved by this hospital and/or the news company listed above. This includes documents and electronic materials made by this hospital as well as the news company.

I understand if the place where these pictures, recordings, or statements go is not a health plan or doctor, the health information released might not be kept private by federal privacy rules.

I understand and agree:

- It is my own choice to sign this consent.
- I can stop filming or recording at any time.
- I or others will not be paid for the use of these pictures, video or audio recordings, or statements.
- My health care and payment for my health care will not change if I do not sign this consent.
- I understand this consent will be good until I cancel it or it will end on __/__/__.
- I may cancel this consent at any time by contacting the Privacy Officer of this hospital by calling: _____. If I do cancel this consent, it will not change any actions taken before my request to cancel is received.

I understand the hospital, its employees, and the doctors are not responsible for anything that may happen from using the materials listed above.

I have read or had this consent read to me.
I understand this consent.
I had my questions answered before I signed this consent.

_____	_____	_____	_____
Signature of Patient or Authorized Representative	Relationship to Patient	Date	Time