COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

HOSPITAL NAME

Consent for Photography/Multimedia and Authorization for Use or Disclosure

Patient or Employee Name: _____

Consent for Photograph or Multimedia

□ **Patient or Patient Representative:**

I hereby consent to be photographed while at name of hospital by its employees to record or document my care or treatment, or other images of me. The term "photograph" includes video, or still photography, in digital or any other format, and any other means of recording or reproducing images, testimonials, and any other later developed mediums and for the purpose of:

_____

*Patient/Patient Representative Signature*_____

□ **Employee:**

I hereby consent to be photographed at name of hospital by its employees, on hospital property, or other areas that the hospital may deem appropriate. The term "photograph" includes video, or still photography, in digital or any other format, and any other means of recording or reproducing images, testimonials, and any other later developed mediums and for the purpose of:

_____

*Employee Signature*_____

Authorization for Use and Disclosure

I hereby authorize the use of the photograph(s) by, or disclosure of the photograph(s) to:

_____
(Person(s)/Organization(s) authorized to receive the information)

_____
(Address: Number, Street, City, State, Zip Code)

This Authorization expires (*insert date):*_____
Upon expiration of this Authorization, the hospital will not permit further release of any photograph(s), but will not be able to call back any photographs or information already released.

Purpose

I hereby authorize the use or disclosure of the photograph(s) for the following uses or purposes (check all that apply):
□ Dissemination to Hospital staff (medical providers, health professionals) □ Emergency/Disaster Notification
□ Educational □ Treatment □ Research □ Scientific □ Public Relations □ Marketing □ News Media
□ Charitable Purposes □ Law Enforcement □ Legal □ Other: _____

Date: _____/_____/_____ Time: _____ AM/PM

I and any persons as my successors agree to release name of hospital and its employees from any claim or cause of action, now or in the future from any claim for injury or compensation resulting from the activities authorized by this agreement.

Patient/Patient Representative or Employee Signature:_____

If signed by someone other than patient, indicate relationship: _____