



# COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

## MANGUM REGIONAL MEDICAL CENTER

### 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 Mangum Regional Medical Center 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:

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*Patient/Patient Representative Signature* \_\_\_\_\_

**Employee:**

I hereby consent to be photographed at Mangum Regional Medical Center 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:

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*Employee Signature* \_\_\_\_\_

#### Authorization for Use and Disclosure

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

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(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 my name, treatment, and/or experience as a patient, including 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  Illustrations  Medical Publications  
 Other: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ AM/PM

I and any persons as my successors agree to release Mangum Regional Medical Center and its employees from any and all claims or cause of action, now or in the future from any and all claims for injury or compensation resulting from the activities authorized by this agreement. I also understand that this material may be used in diverse settings within an unrestricted geographic area.

Patient/Patient Representative or Employee

Signature: \_\_\_\_\_

If signed by someone other than patient, indicate relationship:

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