PHOTO AND VIDEO CONSENT FORM

To be completed following discussion with the patient

PATIENT NAME: _____

PATIENT'S ADDRESS: _____

_____

This authorization grants permission to use your image (still or moving) and/or your spoken words in perpetuity for educational purposes.

By signing this document, you agree:

1. To allow the recording of your image and voice (e.g., photographs, audio, or video).
2. To distribute your image or recording in any medium, be it print or electronic form, which may include the Internet.
3. To grant permission to other entities to reproduce the images or recording for educational purposes.
4. That there is no reimbursement for the right to take, or to use your photograph or video or recording.

Nature of image and/or spoken words to be recorded: _____

_____

Purpose of recording, image and/or spoken words, including the intended audience:

_____

_____

RESTRICTIONS AND LIMITATIONS:

☐ None

Specify, if applicable: _____

_____

I have read and fully understand the intent and purpose of this document and am signing it without reservation.

Name (please print): _____

Signature: _____

Date: _____

Witness: _____

Reset