CONSENT TO PHOTOGRAPH PUBLISH - PATIENT

The undersigned hereby authorizes Tallahassee Memorial HealthCare and my physician(s) to photograph or permit other persons to photograph or interview (name of patient) __________________________ while a patient at a Tallahassee Memorial HealthCare facility or regarding care previously received while a patient at a Tallahassee Memorial HealthCare facility. The undersigned agrees that the hospital and my physician(s) may use and permit other persons to use the negatives or prints prepared from such photographs for the purposes and manners deemed appropriate. The undersigned agrees that these photographs and interviews may be used for purposes including, but not limited to, dissemination to hospital staff, physicians, health professionals and members of the public for educational, treatment, research, scientific, public relations and charitable purposes and that such dissemination may be accomplished in any manner and that such use is subject only to the following limitations:

________________________________________________________________________________________

The undersigned has entered into this agreement in order to assist scientific treatment, educational, public relations and /or charitable goals and hereby waives any right to compensation for these uses by reason of the foregoing authorizations, and the undersigned and his or her successors or assigns hereby hold the hospital, its employees, my physician(s) and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

The term “photograph” as used in this agreement, shall mean motion picture or still photography in any format, as well as videotape, video disc and any other means of recording and reproducing images. The term “interview” as used in this agreement, shall mean any health care related or other personal information that I may disclose verbally or in writing during the course of an interview.

The undersigned may be a patient or a patient’s family member who is participating in a health care activity or event sponsored by TMH. Such events are typically held for specific groups of individuals who have certain health care diagnoses, interests or questions.

Upon my authorization for the use of my picture or any information which I may have disclosed to TMH or to the media during interviews or participation in health care activities or events, I understand and consent to the possibility that protected health information may be disclosed to the public by virtue of the photograph, interview or my presence and participation.

Date: ____________________________________________ Time: _____________________AM/PM

Signature: ____________________________________________________________________________
(patient/parent/guardian)

If signed by other than patient, indicate relationship: ________________________________

Witness: _____________________________________________________________________________

Original: Medical Record        Copy: Patient