

CONSENT TO PHOTOGRAPHY, RECORDING AND/OR PUBLISHING

Official Use Only:

Use this form if the subject to be photographed or recorded is NOT a patient and the product does not involve protected health information. DO NOT USE THIS FORM IF THE SUBJECT OF THE PHOTOGRAPH OR RECORDING IS A PATIENT. If the subject of the photography or recording is a Patient, use either Form No. PF-1 or PF-2, as appropriate.

Print Name (person to be photographed/recorded or owner of product/premises photographed)

Print Address

Telephone

Email

In consideration of the engagement as a model or actor and for other good and valuable consideration, the receipt of which is hereby acknowledged, I hereby permit St. Joseph's Hospital and Medical Center _____ (hereinafter referred to as "**you**" or "**your**") and the persons designated by you, to photograph, and/or make audio and/ or visual recordings, or create images in the likeness of (*name of subject, e.g., employee, model, actor, product, premises, etc.*) _____.

Description of event(s): _____ Date _____

(check one) One time event Series of events

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I waive the right to inspect or approve the finished product(s) and/or the advertising copy or other matter used in connection with the product or the use for which it may be applied. I further waive any claims to royalties or monetary compensation connected with such recordings, creations or photographs, or the publication or distribution thereof.

My signature below confirms that I have the legal right to grant this license to you. I hereby release, discharge and agree to hold you and/or your affiliates, successors, or those acting under your authority or permission, harmless from any liability whatsoever connected with the photography, recording, or creation, or the use, re-use or publication of such images or recordings, including any blurring, distortion, alteration, cropping, or use in composite form, intentional or otherwise, that may occur or be produced in the processing of such products. This consent shall be binding upon me and the subject of this photography or recording (if different), my heirs, agents, legal representatives, and assigns.

ACCEPTED AND AGREED TO

Signature

Date

Print name

Signatory's relationship to the subject (*If signatory is not the subject*)



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CONSENT

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Patient Label