

**CONSENT FOR PHOTOGRAPHING,
VIDEOTAPING, AND/OR AUDIOTAPING**

Consent-E
Consent for Photography, Videotaping and/or Audiotaping



IDN13150341

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

I hereby authorize Rush University Medical Center, its agents and/or employees to make a recording of my voice, image, or likeness in any media whatsoever, including but not limited to photographs, videotape(s), audiotape(s), or any electronic or digital medium.

I understand that the recording(s) may be used for research, diagnostic, therapeutic, educational, or public relations purposes.

I further understand that I have the right to withdraw my consent to a recording being made at any time before the recording is made and for the use of such recording within a reasonable period of time before the recording is used for any of the permissible purposes.

Date: _____

Name

Signature

Signature of Parent/Guardian (if applicable)

**WITHDRAWAL OF PRIOR CONSENT
FOR PHOTOGRAPHING, VIDEOTAPING AND/OR AUDIOTAPING**

I withdraw my prior consent to the recording and/or use of the recording of my voice, image, or likeness in any media whatsoever, including but not limited to photographs, videotape(s), audiotape(s), or any electronic or digital medium.

Date: _____

Name

Time: _____ AM / PM

Signature

Signature of Parent/Guardian (if applicable)

INSTRUCTIONS: This consent form should be signed by the patient if an adult (18 years and older), by a parent or court-appointed guardian if the patient is a minor or by a court-appointed guardian if the patient has been declared legally incompetent. (This form need not be completed if photographing and/or videotaping is incidental to a surgical or medical procedure for which the General Informed Consent form (#1927), which contains an authorizing paragraph, is completed).