UMC
UNIVERSITY
MEDICAL CENTER
NEW ORLEANS

Date_____

Permission for Public Information and/or Photographs

Name of Patient (Print)_____

The attending physician must give approval.

Name of Physician (Print)_____

Physician's approval by initials: _____ If verbal permission please indicate:
Yes No

I / We hereby consent to an interview and/or photographs [still or video] of the above named

patient by representative(s) of _____

____For the purpose of public information (including news media)
____For hospital promotions of patient care
____For research programs/medical education
____Other purpose (please provide a detailed explanation)
(specify):_____.

Permission is voluntary and, as such, I/We relieve and hereby agree to hold the hospital, its representatives and the University Medical Center New Orleans free and harmless from any and all liability arising out of the interviewing, photographing, and/or any subsequent publication or broadcasting of such information or photographs. Any requested restrictions are described below. In granting consent, I/We assume full responsibility and acknowledge that said photographs and /or information may be used at the discretion of the news media or other party named herein. "I/We have the right to rescind authorization/consent before the recording, film or image is used except to the extent that action is taken in reliance of this authorization/consent. Unless otherwise revoked, this authorization/consent will expire on the following date, event, or condition: Post Film / Post Production.

_____ _____
Signature of Patient **If patient is unable to sign, Signature of Next of Kin**

_____
If patient is a minor, Signature of Parent / Legal Guardian

Signatures of Witnesses (1) _____ **(2)**_____

Signature of at least one parent or the legal guardian is required for a minor.
Signature of two witnesses is required when patient is unable to sign.