LSU HOSPITALS
HEALTH CARE SERVICES DIVISION

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 new media)
____For hospital promotions of patient care
____For research programs/medical education
____Other purpose (specify):_____.

Permission is voluntary and, as such, I/We relieve and hereby agree to hold the hospital, its representatives and the LSU Health Sciences Center Health Care Services Division 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.

_____

Signature of Patient

If patient is unable to sign, Next of Kin (Print)_____

If patient is a minor, Parent / Legal Guardian (Print)_____

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.