Use patient /address label or fill in blanks

Patient Name_____

Medical Records #_____

Street Address:_____

City,_____

State, Zip_____

Phone:_____

SIU

PATIENT CONSENT AND AUTHORIZATION TO BE PHOTOGRAPHED, VIDEO/ AUDIOTAPED AND/OR INTERVIEWED

I,_____, give Southern Illinois University School of Medicine and SIU Physicians and Surgeons (referred collectively as SIU Medicine) permission to photograph partial or full images, video and /or audiotaped or interviewed, _____for such purposes as . **Check the appropriate box**. (Specify what is to be photographed or videotaped)

☐ Internal or External Educational or Research Purposes (i.e .medical training, publications, presentations)

☐ SIU Marketing and Public Relations Needs (i.e. news, promotional, including, without limitation, the internet)

☐ Other_____

I understand and agree that such photographs and/or other recordings, and all copyrights and other rights and interests therein, shall be owned exclusively by SIU. I further understand and agree that such photographs and other recordings may be scanned into computers and adjusted electronically and may be edited, cropped, or otherwise modified by SIU at its discretion.

I further authorize SIU to release any pertinent protected health information related to my medical care and treatment to be used or shared for any of the purposes stated above. I understand that the sharing of such information is voluntary by me and my treatment or care is not affected upon my signing of this consent form. I further understand that any sharing of information stated above comes with the risk that the information may no longer be protected. I understand that this consent may be cancelled at any time by giving a written statement to the address listed below*. I understand that the cancellation will not apply to information that has already been released in connection to this consent.

I can refuse to sign this consent for any purpose. I understand a consent is not required for taking of photographs, video/audiotaped, or other media used for the purpose of treatment, operations, and/or payment (i.e. wounds). See signature line below**. I understand I may look at or be given a copy of the information to be used or shared. If I have any questions about the sharing of my health information, I can contact SIU's Privacy Officer in writing (Privacy Officer, SIU HealthCare, PO Box 19639, Springfield, IL 62794). **This consent shall remain in effect unless and until I notify SIU in writing to cancel this authorization.**

I hereby release SIU, its employees and agents, from any and all claims or demands that I might have against any of them to any costs or damages in connection with the use of the photographs, other recordings and my medical information referred to above.

IN WITNESS WHEREOF this consent form is executed this_____day of_____, 20__

. Signature:_____

Printed Name:_____

When outside Media is involved, in addition to scanning this signed document into the patient's record, also send a copy to SIU Public Relations.

Form Updated 10/1/09, Rev. 05/29/2015, 12/14/2017 OCP approved 12-20-2016 Q &S
Form Revised: QRS 5-15-2019: OCP 6-12-2019, Q&S: 6-18-2019