SCHOOL OF MEDICINE
UT HEALTH SCIENCE CENTER™
THE CENTER FOR MEDICAL HUMANITIES & ETHICS

CONSENT FORM

For photos, interviews, audio and video recordings

Date: ____
Patient: ____
Parent or Legal Guardian (if any): ____

I (patient) understand that as a general rule, records of patient identity, diagnosis, evaluation, or treatment are confidential and privileged unless a written consent to their release is submitted. It is my desire to waive confidentiality, ONLY to the extent that my interview, audio or video recording, and/or photograph(s) contains information relating to my identity (including my image and/or likeness), diagnosis, evaluation, or treatment.

I do therefore, hereby consent to be interviewed, audio or video recorded and/or photographed by ___________________________ for the sole purpose of use in promotional materials for The Center for Medical Humanities & Ethics, including print and electronic materials and funding applications.

This consent allows the use, publication, broadcast, telecast, distribution and circulation of my name, photograph, image, and/or likeness for the purpose expressed above and no special favors have been promised to me for agreeing to consent. I may withdraw this consent at any time, and such withdrawal will not in any way affect my treatment. I understand a withdrawal of consent must be made in writing, and that withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal. I understand further, that in some cases my facial features may be visible and/or recognizable. I (or the legal guardian, or parent signing on my behalf) am over 18 years or older, and mentally competent.

I hereby release, indemnify and hold harmless the Center for Medical Humanities & Ethics, its staff and employees from any and all claims or causes of action that I may have, of any nature whatsoever, which may in any manner result from the use of the interview, photos, video or audio recordings.

I HAVE FULLY READ THE FOREGOING "CONSENT FORM." I FULLY UNDERSTAND ITS CONTENTS. I AM SIGNING THIS AS MY FREE AND VOLUNTARY ACT.

*Signed*____ *Date*____________________
Patient, parent, or legal guardian

*Signed*____ *Date*____________________
Witness to signature of patient, parent or legal guardian

*Printed name of witness*____