



SUNY  
DOWNSTATE  
Medical Center  
University Hospital of Brooklyn

Name

MR#:

DOB:

N/S:

Service/Doctor:

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## **AUTHORIZATION FOR PHOTOGRAPHY/ VIDEOTAPING OF PATIENT**

**By signing the back of this form**, I agree to allow photographs and/or videotaping to be taken of:

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**(Patient's Name)**

**By filling in the back of this form**, I have specified the types of photographs and/or videotaping that I will allow.

I have also specified the ways I will allow photographs and/or videotapes to be used.

I understand that I have the right to refuse to agree to have photographs and/or videotapes taken, and that photography and/or videotaping will stop at any time if I request it to stop.

I understand that I may withdraw my agreement to the use of photographs and/or videotapes at any time, EXCEPT that if I agree to the use of photographs and/or videotapes for publication or for use at a seminar or conference outside of Downstate Medical Center, I may withdraw my agreement only until a reasonable time before publication or use.

(over) 





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## **AUTHORIZATION FOR PHOTOGRAPHY / VIDEOTAPING OF PATIENT**

**Please initial all that apply.** Patient or representative agrees to:

☐ Photographs

☐ Audio recordings

☐ Video recordings

☐ Other (specify)

To be taken by: \_\_\_\_\_  
(Photographer's Name)

*If photographer is not a UHB employee, specify photographer's affiliation:*

**Please initial all that apply.** Patient or representative agrees to the following use or uses specified below:

☐ Medical or Nursing Education at UHB and Affiliates

☐ Publication (specify name & date): \_\_\_\_\_

☐ External Seminar or Conference (specify name & date): \_\_\_\_\_

☐ Other (specify): \_\_\_\_\_

**BY SIGNING BELOW, I AGREE TO ALLOW PHOTOGRAPHY  
OR VIDEOTAPING AS I HAVE SPECIFIED ON THIS**

Age at last birthday of person signing authorization: \_\_\_\_\_ years old      Date: \_\_\_\_\_

\_\_\_\_\_  
Patient/Representative Name (Print)

\_\_\_\_\_  
Signature

WITNESS: To be signed by a UHB employee.

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date