Name	
MR#:	DOB:
N/S:	Service/Doctor:

ACKNOWLEDGEMENT OF RULES FOR PHOTOGRAPHY AND VIDEOTAPING DURING LABOR AND DELIVERY

I have requested permission from University Hospital of Brooklyn to have photographs and/or videotape recordings made of me and my baby during my labor and delivery.

The photographs/video will be made by _____
(Print Name)

I agree to the following rules for photography/videotaping at University Hospital of Brooklyn during labor and delivery:

- No other patient will be photographed / videotaped.
- No staff member will be photographed / videotaped without his or her consent.
- The location of the photographer will be decided by a physician or nurse.
- Photography / videotaping must stop from when the baby's head appears until after the initial care of the infant and the attending physician approves the resumption of photography and recording.
- Photography/videotaping must stop if requested by a physician or nurse.
- The photographer will not attempt to photograph / videotape the placement of an epidural, the repair of an episiotomy or any other procedure other than a normal vaginal delivery.
- Photography/videotaping must stop if I am taken to the operating room.
- I understand that University Police will be called to intervene if the person who is making the photographs / videotapes and I do not follow these rules.

BY SIGNING BELOW, I AGREE TO FOLLOW THE RULES FOR VIDEOTAPING THAT ARE SET FORTH ABOVE.

_____	_____	_____
Name of Patient	Signature of Patient	Date
_____	_____	_____
Name of Witness	Signature of Witness	Date