SUNY DOWNSTATE Medical Center
University Hospital of Brooklyn

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

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:

_____

(Patient's Name)

By **initialing** 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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Name	
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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 authorization.

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