Morristown Medical Center
ATLANTIC HEALTH SYSTEM

**Photography, Audiovisual Recordings and Interview Consent Form**

In connection with the medical and hospital services that I am receiving from my physician, Dr. _____ and Atlantic Health System, I consent to an interview and to photographs and/or other audiovisual recordings being taken of me or parts of my body.

Check box if for **Public Purposes** as described below: □

I hereby grant to Atlantic Health System my consent to publish, republish, reproduce, use or reuse the photographs and/or other audiovisual recordings and/or information obtained, including but not limited to my name, likeness, biographical information or other information which may identify me to the public, in television, newspapers, journals, periodicals and other exhibition or public media for any purpose and for use in publicity, marketing and advertising in all media. I hereby waive all rights that I may have to any claims for payment of money or royalties in connection with any publication, exhibition, televising or other showing of the above, regardless of whether it is under philanthropic, commercial, institutional, or private sponsorship, and irrespective of whether a fee for admission or rental is charged.

Check box if for **Medical/Scientific Purposes** as described below: □

I hereby grant to Atlantic Health System my consent to an interview and to photographs and/or other audiovisual recordings being taken of me or parts of my body under the following conditions: (1) That this will be done only with the consent of my physician and under such conditions and times approved by him/her. (2) That the photographs, audiovisual recordings and/or other information obtained shall be used when, in the opinion of my physician, they will benefit medical research, education or science, which may include, but not be limited to the publication, republication, reproduction or use of the above, either separately or in connection with each other in professional journals, medical books, medical, scientific or educational seminars or for any other purpose which may be deemed proper in the interest of medicine, science, medical education, knowledge or research. (3) My identity is not revealed. The aforementioned photographs and/or other audiovisual recordings may be modified or retouched in any way that my physician may consider desirable.

I hereby release Atlantic Health System, its subsidiaries and affiliates, its employees, agents, officers, and trustees and the physician named above, and his/her assistants and any and all other health care personnel attending me from any and all liability of any kind or nature that may result from the taking, printing, retaining and using of said photographs, audiovisual recordings and other information obtained in connections therewith. I attest that I am of full age and am mentally competent to execute this release. I certify that I have read and fully understand this consent, that the explanations referred to were made and that all blanks or statements requiring insertion or completion were filled in.

Date:_____Name of Patient:_____

Signature of Patient:_____ Signature of Witness:_____

Signature of Authorized Agent, Parent or Guardian: _____

Relationship to Patient:_____