

**Consent to Publish, Photograph or Video Record  
By  
Empowerment Resource Center, Saint-Joseph's Health System, Inc. or Other Persons**

Name of Patient, Employee, Client, Volunteer or Visitor: X \_\_\_\_\_  
(print name)

Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

Effective Date: From \_\_\_\_\_ To \_\_\_\_\_

I hereby consent and permit: X \_\_\_\_\_  
(sign)

***Please-Check All That Apply***

1. To use the above person's name in connection with any publication (including but not limited to newspapers, television and/or radio broadcasts, audios, recordings, drawings and sketches, books, brochures, magazines, videotapes, motion pictures, or other publicly distributed materials) in such manner and at such times and in such places as Empowerment Resource Center, Saint Joseph's Health System, Inc. or the administration of the hospital shall determine without restriction at its sole discretion.

2. To take and use photographs, video recordings, slides and any quotation and comment made verbally or recorded or made by the above person for publication or advertising purposes (including but not limited to newspapers, television and/or radio broadcasts, audios, recordings, drawings and sketches, books, brochures, magazines, videotapes, motion pictures, or other publicly distributed materials) in such places as Empowerment Resource Center, Saint Joseph's Health System, Inc. or the administration of the hospital shall determine without restriction at its sole discretion.

3. To take and reproduce photographs, video recordings and/or slides of the person named herein in connection with the diagnosis, care and treatment (including surgical procedures, voice and swallowing purpose and medical broadcast or a trial), or by Empowerment Resource Center, Saint Joseph's Health System, Inc. or any physician associated with Saint Joseph's Health System, Inc., for scientific, research, and/or educational purposes.

4. Empowerment Resource Center and Saint Joseph's Health System, Inc., has my permission to release the following on the behalf of the patient and his/her family members.

Name and Condition Report Statement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The above items constitute an irrevocable consent to release the specified media. I understand and agree that all such materials are the property of Empowerment Resource Center and Saint Joseph's Health System, Inc.

**I have read the foregoing consent, and I am fully aware and understand the contents.**

X \_\_\_\_\_,  
Signature of Patient/Client/Employee/Volunteer/Visitor or Patient Representative

\_\_\_\_\_  
Witness and Date

\_\_\_\_\_  
Town or Residence

\_\_\_\_\_  
Location

\_\_\_\_\_  
Patient Phone Number

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness and Date

Reason Patient Unable to Sign: \_\_\_\_\_

Physician Notified: Yes \_\_\_\_ No \_\_\_\_  
Yes \_\_\_\_ No \_\_\_\_

Media Relations Specialist Notified:

Nursing Dept/HIM notified: Yes \_\_\_\_ No \_\_\_\_