INDIANA UNIVERSITY
SCHOOL OF MEDICINE

PHOTOGRAPHY AND VIDEORECORDING CONSENT FORM

SUBJECT OF THE RECORDING *(for example the patient, family member, research subject)*

Subject's Full Name: _____

Street Address: _____ Apt No.: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____

RECORDINGS:

Date(s) of Recording *(include a series of dates for "serial" Recordings)*: _____

Type of Recording:

☐ Photo ☐ Video ☐ Audio ☐ Illustration ☐ Other: _____

PERSON MAKING THE RECORDING:

The following individual(s) will be making or creating the Recording:
Name: _____
Contact Information: _____

If not an Indiana University employee please also provide:
Company Information: _____

PURPOSE:

You are authorizing Indiana University School of Medicine, Department of Family Medicine at 1110 W. Michigan Street, Long Hall 200, Indianapolis, Indiana 46202 *to release or use the recording described above for the following purposes:*

Patient Care:

☐ Patient Identification, Diagnosis or Treatment: I understand that these recordings will be part of my medical record and subject to the same protections and restrictions on disclosure that apply to other parts of my medical record.

Education or Performance Improvement:

☐ To be part of future educational presentations to teach healthcare clinicians
☐ As part of Indiana University's quality, safety and performance improvement initiatives

Research:

☐ As part of a specific research protocol, Identify the Protocol: _____
☐ For purposes of future research as described here: _____

Other Purposes:

☐ Recording of my person for my own personal use
☐ For display within Indiana University Health to celebrate healing and caring of the Indiana University Health workforce members, such as display on a particular inpatient unit, break room, or other similar space
☐ Promotional Purposes
☐ Other planned use or disclosure of the requested recording:
An article in a external newsletter highlighting the efforts of a third-year medical student to help a patient with achieving a more independent life regarding his healthcare. Patient name will not be released.

PURPOSE *(con't)*:

Communications or Public Relations:

☐ To be disclosed to the media or other third-party, including but not limited to, newspapers, television, radio, internet and other print or electronic media outlets

☐ To be disclosed to the general public for use in marketing materials of Indiana University, Indiana University School of Medicine (IUSM), Indiana University Health, IU Health Physicians, Methodist Health Foundation and/or Riley Children's Foundation

The undersigned hereby transfers and grants to Indiana University the exclusive right to use and to authorize others, including but not limited to, Indiana University, IUSM, Indiana University Health hospitals, IU Health Physicians, Methodist Health Foundation and Riley Children's Foundation, to use all or any part of my interview/photograph/video or film likeness, regardless of the medium by which it is recorded, in the program or article on:

_____

_____

The undersigned also hereby transfers and grants to Indiana University the exclusive right to use and authorize others to use all or any part of my interview/photograph/video in related media such as books, magazines, journals, pamphlets, electronic (Internet) and other written video formats.

The undersigned also hereby releases Indiana University and its directors, its members, trustees, officers, employees and agents as well as IU Health and its agents from any and all claims, demands, causes of action and suits, including but not limited to, claims for invasion of privacy, defamation, breach of contract or other breach of duty arising out of in connection with the use of this interview, photograph or video.

RESTRICTIONS *(If Any)*:

I request the following restrictions apply to the use or disclosure of a Recording:

_____

_____

CONSENT AND RELEASE:

I hereby agree and consent to the Recording and disclosure of my information as described here. I hereby release Indiana University from any liability arising from the taking and using of such Recording.

I understand Indiana University cannot require me to sign this authorization as a condition for providing treatment.

I understand I may ask for the recording process to be stopped at any point during the recording session.

I understand this authorization may be revoked by me at any time by submitting a written request to:

I understand my requested revocation applies to future use of recordings, not recordings Indiana University has already used.

I understand the material released as a result of this authorization may contain identifying information and could be subject to re-disclosure and no longer protected by the laws applying to medical information released.

_____ _____

Signature of Subject or Legal Representative Name and Relationship of Legal Representative

_____

Date