

## Part 1 of 2 Consent for Photography and Recordings for Non-Clinical and Non-Research Purposes

I \_\_\_\_\_ give my permission, as shown below, to be interviewed, photographed, video/audio recorded, or broadcast/webcast live, (each a "Recording"), during interviews, diagnostic/treatment sessions, surgical/medical procedures, celebrations or events.

**I am consenting to:**     Interview                       Photographs/Digital Images     Live Broadcast/Webcast  
(check all that apply)     Audio Recordings     Video Recording/Motion Pictures

I agree that BMP \_\_\_\_\_ may use these Recordings and my information for (check all that apply):

Education and training:

- Within BMP
- Outside of BMP

Inform the public about clinical, educational, scientific, and charitable activities or services of conjunction with:

- Live or taped television, radio or internet broadcasts
- Publications including, but not limited to, articles in a medical journal, newspaper, hospital magazine/ newsletter/website, print/online

Other:  \_\_\_\_\_

I understand that all information provided by me or my care team during the Recordings may be used and disclosed for these purposes. This may include personal or health information about me.

I also understand and agree that:

- I grant and release to BMP \_\_\_\_\_ all rights, title and interest that I may have in these Recordings, including copyrights in the Recordings and rights to use, reproduce, modify, create derivative works of, broadcast and distribute the Recordings.
- My participation is voluntary. I will not receive, and I am giving up any claim to receive, any payment or royalties in connection with any use or disclosure of the Recordings.
- Only individuals who are approved by BMP \_\_\_\_\_ shall conduct or produce the Recordings.
- If any of the Recordings are given to a third party outside BMP \_\_\_\_\_, such as the media, BMP \_\_\_\_\_ cannot control how they will use or share the Recordings.
- The Recordings may be edited, modified, or retouched for artistic and graphic production reasons or to withhold identity.

I  **do**  **do not** authorize my name to be used in connection with these Recordings.

If the Recordings will be shared outside of BMP \_\_\_\_\_ **in any public forum or manner** and they contain information that could be used to identify me (such as: my name, face, voice, demographics) and reveal information about my medical conditions or treatment, I must also sign a HIPAA authorization form (See page 2).

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Name of Individual	Date of Birth	Signature	Date
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(If Applicable) Name of Legally Authorized Representative	Signature	Date
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Relationship of Representative to Individual: \_\_\_\_\_

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Print Staff Representative Name, Title and Entity	Signature	Date
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**PLEASE RETAIN A COPY OF YOUR SIGNED AUTHORIZATION FORM FOR YOUR RECORDS**

