**Consent to Collect, Use and Disclose Stories, Photos and/or Video and Sound Recordings**

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| --- |
| Name of Individual being recorded |
| Address | City/Town | Province | Postal Code | Phone Number |
|  |  |  |  |  |
| Name of Individual giving consent *(Individual or Authorized Representative)* Self | Source of Representative’s Authority*(Attach a copy of the document which authorizes you)* |
|  |  |
| Type of recording  *(check all that apply)* |
|  Still/Digital Photographs |  Sound Recordings |  Video Recordings (with or without sound) |
|  Interviews/Writing/Stories/Narratives |  Other, Specify |
| Scope of Use or Disclosure |  Internal Only |  Both Internal and external to \_\_\_ |
| Purpose of collection and disclosure |
|  Media Release/Interviews |  Publications |  Quality Improvement |
|  Promotions |  Presentations/Displays |  Quality and Patient Safety Reporting |
|  Education |  Website |  |
|  Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name of person or group the recording, story or photo is being shared with *(For example “The General Public”, “Research Papers”, “\_\_\_ Website”)* |
| * I authorize \_\_\_\_\_\_\_ to record me and/or take my photo and use them in communications about \_\_\_\_ programs and services. I understand there are many ways of sharing communication, including printed and electronic methods. I understand that the recording or photo may be shared with a range of people and groups.
* I authorize \_\_\_\_ to use my name, address and telephone number to contact me about this consent.
* I understand why these recordings and/or photos are being taken and how they may be used. I know that there are risks and benefits to giving this consent. I know that I can stop this consent at any time by informing AOS in writing.
* I understand that \_\_\_ cannot control information once it has been shared outside of \_\_\_. I understand that if I ask \_\_\_ to stop using my recordings and/or photos it will only stop additional use of those recordings and/or photos after the date my request is received by \_\_\_.
* I agree to release and discharge \_\_\_ and those that \_\_\_ is responsible for at law from the responsibility and liability of the content and claims for the printed/electronic communication where my information was used. I confirm that this release and discharge shall be binding upon my heirs, executors, administrators and assigns.
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| Date consent is effective *(dd-mmm-yyyy)* | Expiry Date *(dd-mmm-yyyy)* |
|  |  |
| Signature of Individual /Authorized representative giving consent | Date *(yyyy-mmm-dd)* |
|  |  |
| **Witness:** I watched the individual giving consent and sign the consent form *(witness must be at least 18 years of age)* |
|  |
| Name | Signature | Date *(dd-mmm-yyyy)* |
|  |  |  |

The information on this form, together with any record authorizing a representative to act on behalf on the individual, is being collected under section 22 (3) and 23 of the Health Information Act and/or section 33(c) of the Freedom of Information and Protection of Privacy Act for the purpose of recording consent to the disclosure of health information and/or personal information in the specified recording. Information collected on this form will be retained in the client file.