**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. | | | | | | | | | | | | | |
| Date consent is effective *(dd-mmm-yyyy)* | | | | | | | | | | Expiry Date *(dd-mmm-yyyy)* | | | |
|  | | | | | | | | | |  | | | |
| Signature of Individual /Authorized representative giving consent | | | | | | | | | | Date *(yyyy-mmm-dd)* | | | |
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| **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.