Consent for Photography & Videography

I authorize and allow Uvalde Memorial Hospital to take such photographs or videotape of me and/or my family as may be desired to illustrate a procedure, treatment, condition or operation, and to permit such photographs or video images to be published and republished in marketing materials including, but not limited to, professional journals, medical books, advertisements, brochures, newspapers, social media sites, or to be used for any other purpose which Uvalde Memorial Hospital may deem appropriate.

I understand and agree that my identity may or may not be released. I agree to hold Uvalde Memorial Hospital harmless from any and all liability arising from these activities.

_____

Printed Name of Participant

_____ _____

Signature of Participant Date

_____ _____

Signature of Parent or Legally Authorized Representative Date

_____ _____

Signature of Uvalde Memorial Hospital Witness Date

Revised 06/2014