YALE-NEW HAVEN HOSPITAL

PERMISSION FOR PHOTOGRAPH AND OR MOTION PICTURES

PERMISSION FOR MEDICAL PHOTOGRAPH

DATE ____________

I consent that photographs or videotapes may be taken of me or parts of my body described as follows

____

______________________________ by ______________________________
(Person taking photo)

under the following conditions:

The photographs shall be used for medical purposes and if in the judgement of my physician, Dr. ____________, medical research, education or science will be benefitted by their use, such photographs and information relating to my case may be published either separately or in connection with each other in professional journals or medical books or used for any educational, research or scientific purpose my physician deems proper. However, that it is specifically understood that in any such publication or use I shall not be identified by name and responsible efforts shall be made to protect my identity.

I hereby certify that I am 18 or more years of age.

WITNESS: ______________________ ______________________
Signature of Patient

WITNESS: ______________________ ______________________
Signature *(How Related)*

1. Permission must be obtained from the patient (or parent of a minor) when photograph is taken for any purpose.
2. When completed, this form will be placed on the patient's chart, to become part of his medical record. Please note; photographs themselves are not necessarily deemed part of the medical record.

PERMISSION FOR PHOTOGRAPH NOT TAKEN FOR MEDICAL PURPOSES

DATE ____________________

I hereby consent that the pictures described as follows ____

____

or any reproduction of same to be taken of me by ____
(Person taking photo)

may be used by ____ for the purposes

____

I hereby certify that I am 18 or more years of age.

WITNESS: ______________________________ ______________________________
Signature of Patient

WITNESS: ______________________________ ______________________________
Signature (How Related)

CONSENT TO TELEVISING OR TAKING MOTION PICTURES OF PROCEDURE OR TREATMENT

DATE: ____________________

In the interests of medical education and knowledge, I consent to the filming of the operation which is scheduled to be performed on me on or about ______________ , 19______ . I authorize Dr.______________________________ and the Yale-New Haven Hospital to admit to the treatment of procedure area the cameramen and technicians who are to participate in the filming. I grant this consent as a voluntary contribution in the interests of medical education and knowledge:

- ☐ and subject only to the condition that I will not be identified by name in the film or
- ☐ I hereby consent to the use of my name in the film.

WITNESS: ______________________________ ______________________________
Signature of Patient

WITNESS: ______________________________ ______________________________
Signature (How Related)

1. Permission must be obtained from the patient (or parent of a minor) when photograph is taken for any purpose.
2. When completed, this form will be placed on the patient's chart, to become part of his medical record.
   Please note; photographs themselves are not necessarily deemed part of the medical record.