

Name of Patient (Print) _____
CHI Franciscan Health Staff authorized to photograph/videotape/record (print) _____
Other Individual authorized to photograph/record _____ Employer _____

I authorize CHI Franciscan Health (CHI FH) and its affiliated entities and/or attending physicians or staff to photograph, videotape; interview and record - or permit other persons to photograph, videotape, interview and record me for:

- My Physician(s) or Medical Records only**
- Total Body Medical Photography** Referring Physician Name _____
- Medical Procedure (Describe and give date of procedure)** _____

Other: (Please specify) _____

I agree that CHI Franciscan Health may use and permit other persons to use the interviews, negatives, prints, videotapes, videodiscs, digital images and recordings prepared from such photographs or recordings for such purposes and in such a manner as appropriate. I agree that the photographs, interviews or recordings may be disseminated to hospital staff, physicians and other CHI Franciscan Health professionals for educational, training, treatment, research and scientific purposes. The usage is subject only to the following restrictions: _____

I have voluntarily entered into this agreement to assist medical, scientific, treatment, educational, and scientific goals and waive any right to compensation. I also agree to hold CHI Franciscan Health, its parent corporation (Catholic Health Initiatives) and subsidiaries harmless for any damages or losses incurred by such uses.

I understand that I may refuse to sign this authorization, that there is no obligation to participate, and that CHI Franciscan Health will not condition treatment, payment, enrollment in any health plan or eligibility for benefits on my providing authorization for use and/or disclosure of my photographs or interview material.

I also understand that the photographs, recording, video and/or interview material used and/or disclosed pursuant to this authorization may be re-disclosed by a recipient and cannot be controlled by CHI Franciscan Health, its parent corporation or subsidiaries.

I understand that I may revoke this authorization at any time in writing by sending a letter to: CHI Franciscan Health, Medical Records, 1717 South J Street, Tacoma, WA 98405, or by completing the Revocation of Authorization Form.

Date this consent expires: _____

The purpose of these photographs/videotapes has been fully explained to me and I consent to the indicated uses for these photographs/videotapes/recordings.

Patient's Signature: _____ **Date:** _____

Legal Representative Signature (Relationship) _____

Witness _____ Date _____ Time _____

A copy of this signed Consent Form must be added to the patient's medical record.



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CONSENT TO PHOTOGRAPH AND/OR RECORD FOR MEDICAL, EDUCATIONAL SCIENTIFIC PURPOSES