Klamath
ORTHOPEDIC CLINIC
and sports medicine

Patient Name: _____ MRN# _____

Provider: _____ Rm/Bed: _____ Admit. Date: _____

DOB: _____ Sex: _____ CSN#: _____

Patient Authorization and Release for Photograph and Video Recording

I _____understand that photographs and/or videos may be taken of me or parts of my body before, during, and after my procedure/surgery. These images may be shared with staff, other physicians or health professionals, and members of the public for educational and marketing purposes. I hereby give my consent for Dr. _____ to use these photographs under the following circumstances:

I authorize the use of photographs and/or video images (please initial indicating YES or NO below):

_____ YES _____ NO For educational purposes (medical teaching or training).

_____ YES _____ NO For marketing and advertising purposes (website, print, digital, or social media).

_____ YES _____ NO At my request, my photographs and/or video images will only be used as part of my medical record.

By signing below, I confirm the following:

- I have read this release in its entirety and have had all my questions answered to my satisfaction.
- I understand that my participation is voluntary and that if I do not sign this authorization, my healthcare and payment for my healthcare will not be affected in any way.
- I understand that I will not receive compensation for my participation.
- If I wish to withdraw my consent in the future, I may do so up until a reasonable time before the photography or information is used, but I must do so in writing.
- I understand that information disclosed pursuant to this consent may be re-disclosed by the recipient, and that such disclosure may no longer be protected by state or federal confidentiality laws.
- I understand that I have a right to receive a copy of this authorization.
- I understand that this authorization will expire 24 months after the date of signature of this form, but upon expiration I will not be able to call back any photography or information already released.
- I and my successors or assigns hereby hold Dr. _____ and Sky Lakes Medical Center and its personnel harmless from any and all liability which may or could arise from activities authorized by this agreement.

Patient Name: _____ Patient Date of Birth: _____

Patient Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

Physician's Signature: _____ Date: _____