Yale University
School of Medicine

CONSENT FOR MEDIA PHOTOGRAPHS AND INTERVIEWS

DATE: _____ / _____ / _____

I give my consent for:

Yale New Haven Health System (Bridgeport Hospital, Greenwich Hospital and Yale-New Haven Hospital) or Yale University, and/or their representatives or affiliates,
[I have crossed out any organization I do not wish included.]

to take and use photographs or films of me and/or interview me for publicity, educational, marketing, advertising and fundraising purposes through internal publication, external publication, radio, television, video or internet.
[I have crossed out any purposes or media format I do not wish included.]

Such photographs, films and/or interview content will disclose the fact that I have been a patient of Yale New Haven Health System or Yale University and may contain other information about me, including private health information, what I say in the interview, and facts that can be inferred from the photograph or film.

My name may / may not be used. *(Cross out one.)*

Name of Patient/Subject ____

Street Address ____

City, State, Zip ____ Telephone: _______________

Signature of patient/subject ____

Signature of parent/legal guardian/personal representative ____________________________
(if patient or subject is under the age of 18 or otherwise incapable of signing)

If personal representative, please print name and state relationship to patient _________________

____

Name of photographer:____

Name of interviewer: ____

(Over)

- I understand that I am not required to sign this form in order to receive treatment or payment for my care.

- I understand that information used or disclosed under this authorization may be reused by the recipient and may no longer be protected by privacy regulations.

- I understand that I may revoke this authorization at any time by notifying Yale-New Haven Health System and/or Yale University, as applicable, in writing, and the revocation will be effective on the date notified (except to the extent action has already been taken based on my earlier consent).

- I understand that this authorization will expire in 99 years, unless I have given written notification stating otherwise.

- I understand that neither I nor Yale New Haven Health System or Yale University will receive direct or indirect payment for the communication related to this photo, film or interview.

When completed, this form will be retained by Public Affairs, Marketing or Communications staff or other appropriate, authorized person. For photo permission for medical or other nonmarketing purposes, please see appropriate form.