Consent for Photography, Filming and Interviewing

Name (please print): _____

Phone (home): _____ (cell): _____ Email: _____

Patients only:

Site(s) of treatment (hospital/clinic/other): _____Date of birth:_____

Type of treatment (i.e., cancer care, knee surgery): _____

Care provider(s) (doctor, nurse, etc.): _____

Employees and providers only: department, location & job title: _____

I allow the following to interview, video-record and take photos of me:

- **Media outlets**
- **Fairview Health Services** and its subsidiary, as well as the identified affiliates including but not limited to Behavioral Healthcare Providers, Bethesda Hospital, Ebenezer, Fairview Clinics, Fairview Foundation, Fairview Lakes Medical Center, Fairview Maple Grove Ambulatory Surgery Center, Fairview Northland Medical Center, Fairview Ridges Hospital, Fairview Pharmacy Services, Fairview Range Medical Center, Fairview Southdale Hospital, Grand Itasca Clinic & Hospital, HealthEast Clinics, HealthEast Foundation, HealthEast Medical Transport, Institute for Athletic Medicine, University of Minnesota Health Clinics and Surgery Center, PreferredOne, St. Joseph's Hospital, St. John's Hospital, University of Minnesota Masonic Children's Hospital, University of Minnesota Medical Center, Woodwinds Health Campus
- **University of Minnesota Physicians**
- **University of Minnesota** (including the Academic Health Center and University of Minnesota Foundation)

The above may share my information, videos and photos in any of the following: TV newscasts, radio, newspapers, magazines, newsletters, press releases, advertising, brochures, professional/medical journals and other trade publications, videos, audiotapes, podcasts, presentations, websites, social or other media, blogs, professional and staff communications, education, training, research, marketing, fundraising and promotional materials.

I understand that:

- I can refuse to sign this form. If I don't sign it, this will not affect my care, my payment for care or my relationship with any of the groups listed above.
- My recorded information may be used in many ways. I may not be told when it is used. I will not be asked to approve usage again.
- Any photos or videos are the property of Fairview, its partners listed above or media outlets that film or take pictures of me with my permission.
- I will not be compensated (paid) for any use of my image or story. I waive any and all current or future claims related to the use of my image or story under this agreement.
- This form will not expire. If I change my mind after signing it, I may take back this consent by writing to: *Fairview Communications & Public Affairs, 1700 University Ave., M-1115 – 5th Floor, St Paul, MN 55104, Attn: Consent Form.* If I do this, it will not apply to information already released. Fairview and its partners cannot prevent a third party from seeing information after it is released.

☐ I give my consent without any limits.

☐ I give my consent with these limits: _____

_____	_____	_____
Signature of subject or authorized person (If authorized person is signing, please also print name)	**Relationship** (Parent, guardian, power of attorney, etc.)	**Date**

Name of staff person managing this form (please print): _____

FAIRVIEW HEALTH SERVICES MEDIA AUTHORIZATION/CONSENT FORM

(Not part of the final medical record)