

NAME \_\_\_\_\_ SEX M F

MR# \_\_\_\_\_  
AGE / DATE OF BIRTH \_\_\_\_\_

ACCOUNT# \_\_\_\_\_  
(PATIENT PLATE IMPRINT)

OR-102  
Rev. 10/06

**CONSENT and RELEASE for  
RECORDING or FILMING  
(Page 1 of 2)**

I give permission for \_\_\_\_\_  
*Print Name of Department/Division*

to take photographs, films and/or audiovisual recordings of \_\_\_\_\_  
for two years from the date this form is signed. *Print Name of Subject* *Age*

I allow the photographs, films or audiovisual recordings (“Images”) taken of the subject, to be used and released by representatives of The Children's Hospital of Philadelphia and/or its affiliates (“CHOP”) for purpose(s) I have initialed below. CHOP may use and release the Images (and other information I give permission for in this form) for the purposes I authorize below until CHOP no longer has the Images.

I give permission for CHOP to use and release these Images:

\_\_\_ **For treatment, payment and internal activities of CHOP, for example:**

- Diagnosis and/or treatment of the patient by clinicians.
- Providing information to insurance companies for purposes of supporting requests for payment.
- Internal activities such as staff training and improving the quality of care.

\_\_\_ **For educational activities outside of CHOP, for example:**

- Publications in medical textbooks and journals.
- Presentations to professional and/or medical boards/societies.

\_\_\_ **For marketing and media relations activities of CHOP, for example:**

- Hospital publications and or videos
- Broadcast or print media, including television, radio, newspaper, magazines, and the Internet
- Printed materials (brochures, posters, etc.)

\_\_\_ **Other** (*describe any other purpose for which the Image will be used or released, including a description of who will use the Images within CHOP and/or receive the Images outside of CHOP*):

\_\_\_\_\_  
\_\_\_\_\_

**Permission to Use and Release Subject Name and Other Information with the Images:** Some Images themselves may identify the subject (for examples, pictures that show a subject’s face). In some cases, CHOP may wish to use or release the subject’s name along with the Images. Please initial one of the following for use of the subject’s name with the Image:

\_\_\_ **I agree** to the use and/or release of the subject’s name with the Images.

\_\_\_ **I do not agree** to the use and/or release of the subject’s name with the Images.

I also allow the following subject information to be used and/or released along with the Images:

\_\_\_\_\_  
\_\_\_\_\_

NAME

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(Page 2 of 2)**

**Understanding this Authorization:**

- My decision to sign this authorization will not usually affect the subject's ability to get care at CHOP. At times, CHOP may be required to record or film the subject to provide medical services. If I do not agree to recording or filming in these situations, services may not be provided.
- I understand that CHOP may use and release Images as the law requires or allows without further permission from the subject, even if I do not agree. See the CHOP Notice of Privacy Practices for details about how medical information, including Images, may be used and shared -- [http://www.chop.edu/about\\_chop/hipaa/npp.shtml](http://www.chop.edu/about_chop/hipaa/npp.shtml)
- After signing this form, I can change my mind and ask that recording or filming stop. If I change my mind after recording or filming is done, I can notify the CHOP Department / Division indicated above in writing to ask that the Images not be used or released. This will not change any use or release of the Images by CHOP before receiving my notice. If the Images were released outside of CHOP, I understand the Images may continue to be used even after I withdraw my permission for CHOP to use or share them.
- If I allow CHOP to release Images to other individuals or organizations, I understand that the recipients could use, distribute, broadcast and/or publish them in ways that do not protect the subject's privacy and that CHOP cannot control.
- The Images belong to CHOP. I will not be paid for the use or release of the Images.

By signing, I understand that I am authorizing CHOP to take, use and release Images of the subject as described above.

<b>Signature</b>	<b>Print Name</b>	<b>Date</b>
Relationship to Subject: <input type="checkbox"/> Subject <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____		

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**TO BE COMPLETED by CHOP STAFF**

**Brief description of Image:** \_\_\_\_\_

**Indicate type of Images taken:**  Photograph  Film  Audio Recording  Other: \_\_\_\_\_

**Print name of individual taking the Images and indicate affiliation with CHOP by checking below:**

CHOP Employee  Contractor  News Media  Other \_\_\_\_\_

**Print name of Hospital representative supervising the recording:**

**Location where Images will be stored, if other than the patient's medical record:**  
\_\_\_\_\_