



# COMMUNITY REHAB PHYSICAL THERAPY

## Authorization and Consent to Photograph, Record, Interview and Publish Information, Statements or Images

I consent to Community Rehab, Inc. to photograph or permit other persons to photograph, record, conduct media interviews and/or publish information, statements or images regarding \_\_\_\_\_ obtained while under the care of Community Rehab.

**(Print Patient's Name)**

I agree that the photographs and/or radio or television broadcast tape may be used in publications or in broadcast format with radio or television. I agree that Community Rehab, Inc. may use and permit other persons to use the negatives or prints prepared from such photographs for such purposes and in such manner as either may deem appropriate. I understand and agree that the photographs, recording and/or publication may reveal the patients identity. I agree that the photographs may be used for any purposes including, but not limited to dissemination to, physicians, health professionals and members of the public for education, treatment, research, scientific, public relations, promotional and charitable purposes and that such disseminations may be accomplished in any manner and that such use is subject only to the following limitations.

I consent to the taking and use of photographs, recordings and interviews of me, and to the publication of such photographs, recordings, and interviews, and to the publication of information, statements of images of or about me, in order to assist scientific treatment, educational, promotional, public relations and charitable goals. By signing this authorization and consent form, I hereby waive any right to compensation for such uses, and I my successors or assigns hereby hold the hospital, its administrators, directors, officers, employees or agents and related entities, and the attending physician and their successors and assigns harmless from and against any claim for any injury, and any compensation, resulting from the activities authorized by me in this consent form.

The term "photograph" as used in the foregoing agreement, shall mean motion picture or still photography in any format, as well as videotape, videodisc and any other mechanical means of recording and reproducing images.

I hereby waive my right under relevant state and federal laws including HIPPA, to patient confidentiality with respect to the taking or publishing of any photograph, record, interview, statement or image of me, as authorized in this consent form, with the exception of those limitations specifically identified by me in this consent form. I understand that I have the right to revoke this waiver, and to revoke my consent and authorization in this form, at any time, by notifying the hospital in writing, and discussed herein.

**By signing below, I acknowledge that I have read and understand the above and agree to the terms of this consent.**

**Dated:** \_\_\_\_\_, 20\_\_\_\_ **Hour** \_\_\_\_\_ **am/pm** **Signature** \_\_\_\_\_

**Patient/Legally Authorized Representative:** \_\_\_\_\_

**If signed by other than patient, indicate relationship:** \_\_\_\_\_

**Community Rehab, Inc. Representative:** \_\_\_\_\_