SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

Department logo & contact can be inserted here (VMC, PH, BH, Custody, VHP)

1 Full Name:_____
Date of Birth:_____
If applicable, Medical Record #_____
Address:_____
City:_____
State:_____ Zip Code:_____
Tel:_____

PHOTOGRAPHY CONSENT

2 AUTHORIZATION:

The purpose of this form is to document your consent for the Santa Clara Valley Health & Hospital System (SCVHHS) to obtain, produce, and/or use a verbal or written statement, photograph, digital image, and/or video or audio recording containing your likeness or voice for non-treatment purposes.

The photograph, digital image, and/or video or audio recording will be produced while I am (*describe the activity or situation*) **(To be completed by SCVHHS, if applicable)**

_____

_____

3 PURPOSE:

By signing this form, I am consenting to this photography production and use for the following purpose(s):

☐ Education/Teaching ☐ Presentation/Conference ☐ Quality Review ☐ Performance Improvement
☐ Website ☐ Social Media Post ☐ Marketing Campaign ☐ Printed Materials (brochures, advertisements, etc.) ☐ News Organizations: _____
☐ Other : _____

4 MY RIGHTS:

- SCVHHS will not alter the conditions of my treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide, this consent.
- I am not required to consent to SCVHHS' request to obtain and use my photograph. I may rescind my consent at any time prior to or during production of a photograph, digital image, or video/audio recording, or before/during making a statement.
- I may rescind my consent after production is complete if compliance with that request is not unreasonably burdensome or unlawful considering the financial and administrative costs, ease of compliance, number of parties involved, or legal requirements.
- I waive any right to compensation for use of any statement, recording, photograph, or image obtained under this authorization.
- I, and my successors, hereby released and hold harmless SCVHHS, its agents, officers, and employees from liability resulting from or attributable to any of the procedures and actions authorized above.
- I have read and understood this document, and I consent to the use of a statement from me, and/or of my likeness and/or voice as specified for the above described purpose(s). I understand that consent is voluntary.

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Full Name	Signature	Date

If applicable, Representative Name	Representative Signature	Relationship	Date

IMPORTANT: If SCVHHS is providing or releasing any protected health information, additional written authorization may be required.