



BRODY SCHOOL of MEDICINE

CONSENT TO PHOTOGRAPH AND PUBLISH

The use of medical photography (motion picture, still photography in any format, as well as videotape, video disc, and any other means of recording or reproducing images) has been recommended by physician or other healthcare provider: _____ within The Brody School of Medicine and ECU Physicians for the purpose(s) of diagnosing and/or treating my condition, research, professional education and/or professional publication.

I give the Brody School of Medicine, ECU Physicians and/or my physician or other healthcare provider permission to obtain and use medical photography for the following purposes:

- | | | |
|-------|-------|--------------------------------------|
| YES | NO | |
| _____ | _____ | Diagnosis/treatment of my condition. |
| _____ | _____ | Research. |
| _____ | _____ | Professional Education. |
| _____ | _____ | Professional Publication. |

I understand that this consent will remain in effect unless I instruct the Brody School of Medicine, ECU Physicians, my physician or other healthcare provider in writing that I no longer wish to be photographed or to have the photographs used for diagnosis/treatment, research, professional education and/or professional publication.

I understand that I must also complete a HIPAA privacy authorization form in order for ECU Physicians or the Brody School of Medicine to obtain and use such medical photography (as defined above) if such medical photography is (i) used for research, professional education or professional publication; and (ii) contains any identifying protected health information that may be used to identify me.

I enter into this agreement in order to assist in my care treatment, for research, professional educational and/or professional publication and waive any rights to compensation. I agree to hold harmless the Brody School of Medicine, ECU Physicians, my physician or other care providers from any claim for injury or compensation resulting from the activities authorized by this agreement.

DATE: _____ TIME: _____ AM/PM

SIGNATURE: _____ RELATIONSHIP _____
(patient/responsible party)

WITNESS: _____

Original: Medical Record
Copy: Patient/Responsible Party