YALE-NEW HAVEN HOSPITAL

PERMISSION FOR PHOTOGRAPH
AND OR MOTION PICTURES

PERMISSION FOR MEDICAL PHOTOGRAPH

DATE _______________

I consent that photographs or videotapes may be taken of me or parts of my body described as follows

___________________________________________________________________________________

by __________________________ (Person taking photo)

under the following conditions:
The photographs shall be used for medical purposes and if in the judgement of my physician,
Dr. _______________ , medical research, education or science will be benefitted by their use, such
photographs and information relating to my case may be published either separately or in connection with
each other in professional journals or medical books or used for any educational, research or scientific
purpose my physician deems proper. However, that it is specifically understood that in any such publication or
use I shall not be identified by name and responsible efforts shall be made to protect my identity.
I hereby certify that I am 18 or more years of age.

WITNESS: ___________________________                         Signature of Patient

WITNESS: ___________________________                         Signature               (How Related)

1. Permission must be obtained from the patient (or parent of a minor) when photograph is taken for any purpose.

2. When completed, this form will be placed on the patient’s chart, to become part of his medical record.
   Please note; photographs themselves are not necessarily deemed part of the medical record.

F-1444 (R090596)
PERMISSION FOR PHOTOGRAPH NOT TAKEN FOR MEDICAL PURPOSES

DATE ______________________

I hereby consent that the pictures described as follows __________________________________________

____________________________________________________________________________________

or any reproduction of same to be taken of me by __________________________________________ (Person taking photo)

may be used by __________________________________________ for the purposes __________________________________________

I hereby certify that I am 18 or more years of age.

WITNESS: __________________________________________ Signature of Patient

WITNESS: __________________________________________ Signature (How Related)

CONSENT TO TELEVISING OR TAKING MOTION PICTURES OF PROCEDURE OR TREATMENT

DATE: __________________________________________

In the interests of medical education and knowledge, I consent to the filming of the operation which is scheduled to be performed on me on or about ________, 19____. I authorize Dr. __________________________________________ and the Yale-New Haven Hospital to admit to the treatment of procedure area the cameramen and technicians who are to participate in the filming. I grant this consent as a voluntary contribution in the interests of medical education and knowledge:

☐ and subject only to the condition that I will not be identified by name in the film or
☐ I hereby consent to the use of my name in the film.

WITNESS: __________________________________________ Signature of Patient

WITNESS: __________________________________________ Signature (How Related)

1. Permission must be obtained from the patient (or parent of a minor) when photograph is taken for any purpose.

2. When completed, this form will be placed on the patient’s chart, to become part of his medical record.
   Please note; photographs themselves are not necessarily deemed part of the medical record.