WESTERN MISSOURI MEDICAL CENTER

Photo/Video/Interview Consent

Name:_____ Phone Number: _____

Email:_____ Date of Birth: _____

Please check the box below to give your authorization. You must check this box for WMMC to use your photos, videos, or interviews.

□ I authorize Western Missouri Medical Center (WMMC), its employees, and its agents to record, utilize, republish, exhibit (in print, online, or otherwise), license to third parties, edit, and share interviews and/or photos/videos captured via cameras (such as video, film, digital, phones, tablets, PDAs), audio devices, or any other recording technology (collectively, "Recordings").

This authorization includes use of my photos, videos, interview recordings, and/or quoted statements for the following purposes:

- Marketing and promotional materials
- Educational or training use
- Public awareness efforts
- News and media publication
- Any additional purpose described by me in this form

If you would like to place any limits on how your Recordings may be used, please describe below:

_____

_____

Important Information

- I understand that no private health information (PHI) will be shared unless I voluntarily provide it in an interview.
- I may revoke this authorization at any time, except to the extent action has already been taken based on it.
- I understand the Recordings become the property of WMMC, and I will not receive payment or royalties.
- I release and hold harmless WMMC, its employees, agents, representatives, subsidiaries, affiliates, successors, and assigns from any claims or liability related to the capture, use, or disclosure of any Recordings.
- Signing this form does not affect my treatment, payment, enrollment, or benefits at WMMC.
- Once shared, the Recordings may be further disclosed by others and may lose federal privacy protections.
- Copies of this form, shall be deemed as effective and enforceable as the original.
- I sign this form voluntarily and understand its nature and purpose.

Signature of Patient (if 18 years of age or older): _____ Date: _____

Signature of Parent or Legal Representative (if patient is under 18):_____

Relationship to Patient: _____ Date: _____