Ascension
St. John Hospital

addressograph

REQUEST AND AGREEMENT TO PHOTOGRAPH / RECORD

I am requesting permission to photograph / record images of _____
(Name of patient)

for the purpose of _____.

I understand and agree that we must have the express permission of the appropriate physician / manager.

I agree not to interrupt or interfere, in any way, with the delivery of care to the patient.

I understand and agree that I will not photograph or record the voice or image of any physician, nurse, or other staff member.

I agree not to videotape any equipment that is not in direct contact with the patient. For example, the photograph may include linens, dressings, lines and leads connected to the patient. Ventilators, infusion pumps, electronic monitors, and other bedside equipment are not to be photographed.

I understand that the hospital will not accept responsibility for damage, loss, theft, or any contingency that may occur while the camera or other imaging equipment is on hospital premises. I accept full responsibility and liability for the camera/equipment while on hospital premises.

I, the undersigned, have read this agreement and release. I fully understand it and will comply with all the provisions.

Signature of Patient _____ Date_____ Time_____

Signature of Photographer/Videographer _____ Date_____ Time_____

Signature of Physician/Manager _____ Date_____ Time_____

ATTACHMENT 1: PHOTOGRAPHY, VIDEO AND AUDIOVISUAL RECORDING