



CONSENT TO PHOTOGRAPHY

I, _____, by signing this form on the line below authorize Hartford Hospital, its employees, agents and attending medical staff to record or document, examinations, medical procedures, surgical procedures and other images of me through the means of photography, videotape, audiotape, motion picture or digital imaging, and any other later developed mediums which result in the permanent documentation of the patient's image for the following uses and purposes:

- Use in connection with my care and treatment.
- Use in connection with medical research and education.
- Use by the Hospital for public relations and/or advertising purposes.
- Use by the news media.
- As a courtesy to me per my request.
- Other purposes (please specify): _____

I agree that my photographs taken by Hartford Hospital, which are not required by law to be retained, may be disposed of by Hartford Hospital, provided the manner of disposition shall be permanent destruction.

I hereby waive all rights and release Hartford Hospital from any claim or cause of action, whether now known or unknown, for defamation, invasion of right to privacy, publicity or personality or any similar matter, or based upon or relating to the use and exploitation of my name, image and likeness in connection with the aforementioned advertising and publicity materials.

This consent may be revocable by me at any time.

Patient / Legal Representative

Print Name

Date