

**GENERAL RELEASE AND CONSENT FOR
AUDITORY AND/OR VISUAL REPRODUCTION**

Patient Name (Please Print) _____

Birth Date _____ Hospital _____

If patient is under the age of 21, have mother, father or legal guardian co-sign with patient:

Parent or Guardian (Please Print)

Parent or Guardian (Sign)

I certify that I am the (check one) _____ Mother; _____ Father; _____ Legal Guardian of the patient.

If patient is incompetent, have legal guardian sign in lieu of patient:

Parent or Guardian (Please Print)

Parent or Guardian (Sign)

For value received, the receipt of which is hereby acknowledged, I hereby authorize the University of Miami School of Medicine, its employees, members of its staff and faculty, including but not limited to its Department of Biomedical Communications, (hereinafter collectively referred to as "University") to take such photographs, television recordings, live television trans-missions, videotapes, and motion pictures of the patient, and his or her body, in whole or in part, as they may wish. I hereby authorize them to publish, display, perform, or otherwise use such photographs, in any manner that they in their sole discretion, may consider proper, in the interest of scientific and professional education, knowledge, and research. I further authorize the inclusion of the photographs, television recordings, live television transmissions, videotapes, and motion pictures in educational presentations which the University may perform for its own purposes and programs or may loan, sell, or otherwise distribute to others outside the University for purposes of scientific and medical education. I understand that upon such loan, sale, or other distribution, the presentation containing the patient's likeness may be viewed by persons outside of the University and agree that such publication will not constitute an invasion of the patient's privacy.

I hereby waive any right to inspect or approve any presentation in which the patient appears, in whole, or in part, authorize the University to modify, retouch, or edit any photographs, television recordings, live television transmissions, videotapes and motion pictures of the patient, in any way that may be considered desirable, and waive any right to approve or receive notice of the specific use to which they may be applied.

I understand that, although the patient's likeness may be identifiable, his/her name will not be used.

I hereby waive any right to share in any proceeds which may be obtained from the sale of presentations containing the patient's likeness but agree that such presentations may be shown for any educational, medical, or scientific purpose within the sole discretion of the University or persons purchasing such presentations from the University, and whether on a for-profit or not-for-profit basis.

I hereby release the University of Miami, University of Miami School of Medicine, its agents, employees, faculty, staff, technicians and all persons associated with the production of any photographs, television recordings, live television transmissions, video-tapes and motion pictures in which the patient appears, from all claims, demands, losses, damages, debts, actions, causes of action, attorneys fees and costs of all litigation whatsoever, related to and arising out of the production, publication, or performance of such photographs, television recordings, live television transmissions, videotapes and motion pictures made pursuant to the consent given herein.

I understand and accept all of the above conditions.

Signature (Patient) _____

Signature (Parent or Guardian) _____

Date _____

Witness _____

Date _____

Signature of person obtaining this consent _____

Date _____