



Date \_\_\_\_\_

## Permission for Public Information and/or Photographs

Name of Patient (Print) \_\_\_\_\_

The attending physician must give approval.

Name of Physician (Print) \_\_\_\_\_

Physician's approval by initials: \_\_\_\_\_ If verbal permission please indicate:  
Yes No

**I / We hereby consent to an interview and/or photographs [still or video] of the above named**

**patient by representative(s) of** \_\_\_\_\_

\_\_\_\_ For the purpose of public information (including news media)

\_\_\_\_ For hospital promotions of patient care

\_\_\_\_ For research programs/medical education

\_\_\_\_ Other purpose (please provide a detailed explanation)

(specify): \_\_\_\_\_.

Permission is voluntary and, as such, I/We relieve and hereby agree to hold the hospital, its representatives and the LSU Health Care Services Division free and harmless from any and all liability arising out of the interviewing, photographing, and/or any subsequent publication or broadcasting of such information or photographs. Any requested restrictions are described below. In granting consent, I/We assume full responsibility and acknowledge that said photographs and /or information may be used at the discretion of the news media or other party named herein. "I/We have the right to rescind authorization/consent before the recording, film or image is used except to the extent that action is taken in reliance of this authorization/consent. Unless otherwise revoked, this authorization/consent will expire on the following date, event, or condition: Post Film / Post Production.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**If patient is unable to sign,  
Signature of Next of Kin**

\_\_\_\_\_  
**If patient is a minor, Signature of Parent / Legal Guardian**

**Signatures of Witnesses (1)** \_\_\_\_\_ **(2)** \_\_\_\_\_

Signature of at least one parent or the legal guardian is required for a minor.  
Signature of two witnesses is required when patient is unable to sign.