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## PERMISSION FOR PUBLIC INFORMATION AND/OR PHOTOGRAPHS

Date \_\_\_\_\_

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 new media)

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

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

\_\_\_ Other purpose (specify): \_\_\_\_\_.

Permission is voluntary and, as such, I/We 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. 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.

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

If patient is unable to sign, Next of Kin

(Print) \_\_\_\_\_

If patient is a minor, Parent / Legal Guardian

(Print) \_\_\_\_\_

**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 gives verbal consent, but is unable to sign.*