CNPHTO

PHOTO CONSENT

I hearby consent to be photographed while receiving treatment at a CGH Medical Center facility. The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I hearby authorize the use of the photograph(s) by, or disclosure of the photograph(s) to:

CGH Medical Center
100 E. Lefevre Rd.
Sterling, IL. 61081

PURPOSE:

I consent to be photographed and authorize the use or disclosure of such photograph(s) in order to assist:

Yes	No	
☐	☐	**Medical Treatment and Diagnosis**
☐	☐	**Quality Improvement Projects**
☐	☐	**Public Relations, Marketing, and Charitable Purposes**
☐	☐	**Other**

I and my successors or assigns hereby hold CGH Medical Center, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

MY RIGHTS:

I may request that filming or recording be discontinued at any time.

I may rescind this Authorization up until a reasonable time before the photograph is used, but I must do so in writing and submit it to the following address:

CGH Medical Center
Attention Health Information Department
100 E. Lefevre Rd.
Sterling, IL. 61081

I may inspect or obtain a copy of the photograph whose use or disclosure I am authorizing.

I have the right to receive a copy of this Authorization.

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by Illinois law and may no longer be protected by federal confidentiality law (HIPAA).

I understand I will not receive any financial compensation.

SIGNATURE:

Signature:_____ Date: _____ Time:_____ AM/PM
(patient/representative/spouse/financially responsible party)

Print Name:_____ Relationship if signature other than patient:_____

Signature:_____ Date: _____ Time:_____ AM/PM
(witness)