Western Health

CONSENT FOR PHOTOGRAPHS AND/OR AUDIO/VISUAL RECORDINGS

I, _____, consent to the following for
(Name of Consenting Party)

_____
Myself or Other (state name and relationship of person for whom consent is given)

- ☐ Photographs
- ☐ Audio Recording
- ☐ Visual Recording

as required for the purpose of:

- ☐ Accurate Identification
- ☐ Education
- ☐ Training
- ☐ Media Relations
- ☐ Public or Other Group Activities
- ☐ Other _____

The purpose of the photographs and/or audio/visual recordings has been explained to me by _____ and all questions I had were answered to my satisfaction.

I understand the photographs and/or audio/visual recordings are the property of Western Health.

_____ _____
Signature of Person Giving Consent Signature of Health Care Provider

_____ _____
Relationship (to client/patient/resident) Date