THE UNIVERSITY OF CHICAGO MEDICAL CENTER
RELEASE AND CONSENT TO PHOTOGRAPH A PATIENT FOR NON-PATIENT CARE USES

1. I consent to the taking of photographs of me by:
_____________________________________________________________________
on behalf of the University of Chicago Medical Center (“UCMC”) and/or the
University of Chicago (“U of C”) and allow UCMC and/or U of C to and allow the
use the photograph for the following purposes:

[Insert purposes] __________________________________________________________

_____________________________________________________________________

2. I understand that the photographs may be used to teach medical, nursing, and other
health care students who are working at UCMC or U of C, in journals and other
publications, in marketing materials, or in other public materials.

3. I HEREBY RELEASE THE UNIVERSITY OF CHICAGO MEDICAL CENTER
AND THE UNIVERSITY OF CHICAGO AND ITS EMPLOYEES FROM ALL
CLAIMS OR LIABILITIES RELATING TO THE USE OF THE PHOTOGRAPHS.

____________________________________________________
Name of the Individual Name of Legal Representative*

____________________________________________________
Signature of the Individual or Relationship of Legal Representative*

____________________________________________________
The Individual’s Legal Representative*

____________________________________________________
Name of Witness Signature of Witness

*The Legal Representative is the person authorized to sign on behalf of the individual, for
example the parent or legal guardian.