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.