ST. VINCENT'S MEDICAL CENTER
Bridgeport, CT 06606

CONSENT FOR PATIENT PHOTOGRAPHY, RECORDING OR INTERVIEW

I hereby authorize St. Vincent's Medical Center, or anyone authorized by St. Vincent's, to take
(check as many as apply)

☑ Photographs ☐ Video recordings ☐ Audio recording ☐ Interview ☐ Reprint letter/testimonial

I hereby authorize the use of formats selected above for use in the following: (initial authorized uses only)

____ My medical care
✓ Medical education
✓ Medical and/or scientific
✓ Public relations/marketing
✓ Other as specified Case Study Submission.

I have the right to request filming or recording be stopped at any time during the process. I understand that use of the photographs, recordings, interview notes for education and public relations may involve their publication in professional journals, medical books, audio-visual materials, or public relations, promotional or marketing materials. By initialing the boxes authorizing use for medical and/or scientific publication, medical education and public relations purposes, I hereby consent to and authorize such publication by the Medical Center or anyone authorized by the Medical Center. I also have the right to cancel my consent for use until a reasonable time before the recording or film is used.

✓ I further AUTHORIZE the Medical Center to use my name in connection with any publication of the photographs/recordings.

____ I DO NOT AUTHORIZE the Medical Center to use my name in connection with any publication of the photographs/recordings.

I understand that anyone who engages in recording or filming (who is not already bound by St. Vincent's confidentiality policies) signs a confidentiality statement to protect my identity and confidential information. I have not been promised, nor do I expect, any compensation for granting this consent. I hereby release, indemnify and hold harmless the Medical Center, its affiliated entities and their respective officers, employees and agents from any liability or other obligations arising from the taking or use of the photograph(s), recording(s), or interviews including, without limitation, liability for any misrepresentation/mischaracterization, blurring, distortion, alteration, optical illusion, or use in composite or any other form, whether intentional or otherwise.

Photocopies of this signed Consent shall be as valid as the original.

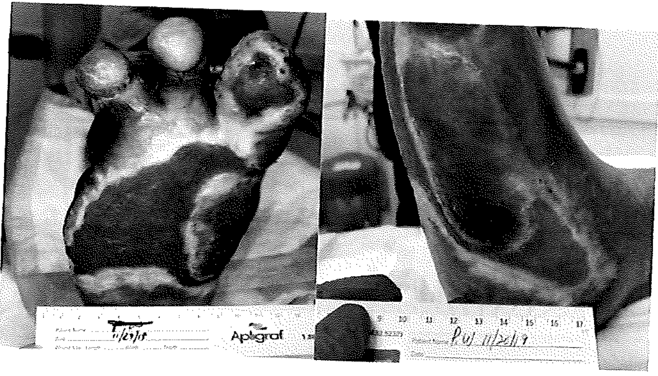
Print Patient Name: Patricia White
Medical Record Number: 00190641

Signature of Authorized Representative/ Date: T/C [signature] T/C per Dr. Dan Davis
Relationship to Patient: Wound Nurse Podiatrist VT/C Dr. Dan Davis.

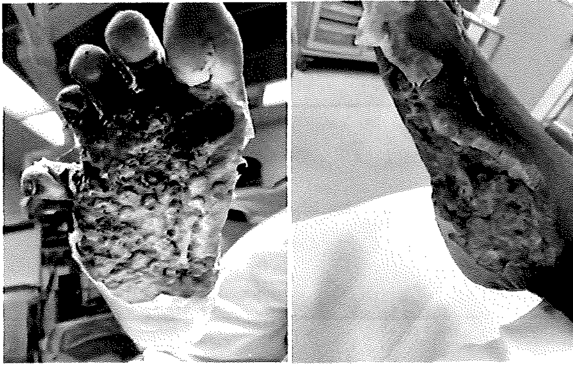
Signature of Patient/ Date:
Signature of Witness: [signature]

Reason for signature other than patient: Pt unable to get to wound center or Hospital to sign. Consent.

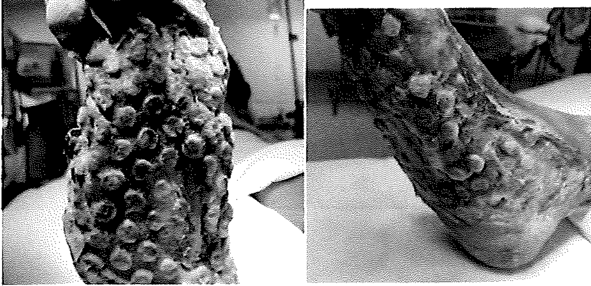
70-181 (11/04)



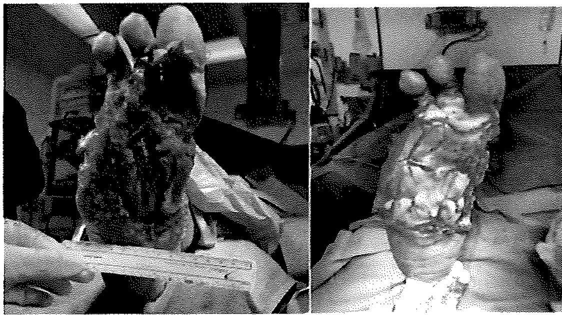
11/27/19



Veraflo
5/20/19



Veraflow
5/24/19



graph
f/b regular Vac
5/24/19