

**Request and Consent to Photography and/or Video Recording**

I hereby authorize Insight Orthopedic Specialists or any of his assignees to take photographs, slides, and videos. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used to document a medical condition, help with the diagnosis and/or treat a condition, to help plan details and/or outcomes of surgery, physical therapy, for communication with other healthcare professionals, educational publications, journals, and educational lectures. The content may also be used for advertising purposes, including website publication, social media posts, print advertisements, and any other marketing material.

I further understand that if the photographs, slides, and videos are used in any publication, promotion material or as a part of a demonstration, my information (first name and last name initial, age, and description of services) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing as explained below.

I hereby authorize Dr. Gemayel, including the attending doctor or other designated person(s), to photograph and/or video record me for the following purposes: Check **YES** or **NO.**

1. For the advancement of not-for-profit medical purposes, including teaching, research and education. I understand that education is an important part of Insight’s mission. **YES** \_\_\_\_ **NO** \_\_\_\_

2. To show or release to current or future Insight patients for the purpose of education and consultation. I understand these photos or videos can be taken at any time during my treatment which includes pre-treatment, post-treatment, pre-operative, intra-operative, post-operative photos and/or videos of my treatment, surgery and/or procedure. **YES** \_\_\_\_ **NO** \_\_\_\_

3. For external educational purposes outside Insight such as social media posts with professionals and students, lectures and presentations at professional conferences.

**YES** \_\_\_\_ **NO** \_\_\_\_

● I consent to photographs and/or video recordings under the following conditions:

● Copies of the photos, videos, and/or films may be released to me if I ask for them,

● I can refuse to have photos and/or video taken without any change in my medical care at Insight. ● I understand and agree that although my name will not be used, it may be possible to identify me from a photo and/or video, and ● I understand that once released outside Insight, Insight does not have control over the photos or videos.

**Revoking Permission:** This authorization has no expiration date, but I may revoke it at any time by writing to the Health Information Management Department. I must state in writing that I no longer give consent for photo(s) and/or video(s) or for the use of any photo(s) or videos(s) that were already taken.

I have had enough time to discuss with my provider the information on this form. I have had the chance to ask questions and all my questions have been answered. I have read and understood the information. I hereby release Insight, its personnel, and any other persons participating in my care from any and all liability which may or could arise from the taking or authorized use of such photographs and/or video recordings.

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Printed Name Signature of Patient or Authorized Representative

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DOB Date Signed