REPUBLIC COUNTY HOSPITAL
PATIENT CONSENT FOR PHOTOGRAPHING, VIDEOTAPING, AND/OR AUDIOTAPING MEDICAL/SURGICAL PROCEDURES

I,______________________________authorize Republic County Hospital to do the following (check one that applies):

□photograph □videotape □audiotape

I understand that the photographs, videotapes, and/or audiotapes are to be used for (check all that apply):

□documentation/monitoring
□research □diagnostic □therapeutic □educational purposes □public relations

This is subject to the following restrictions (If none, leave blank):____________________
____
____

Date photographing, videotaping, and/or audiotaping to be done:____________________

If videotaping and/or audiotaping, please complete the section below.

□ I do not wish to have any other persons (other than those deemed necessary by the attending physician) present during the above stated procedure.
□ I agree to allow additional individuals to be present during the above stated procedure. (List the additional individuals you consent to be present.)

____
____
____

____________________________________ ____________________
Signature of Patient or Patient's Personal Representative **Date**

____________________________________ ____________________
Witness **Date**

____________________________________ ____________________
Witness **Date**

INSTRUCTIONS: This consent form should be signed by the patient if an adult (18 years or older), by a parent or court-appointed guardian if the patient is a minor, or by a court-appointed guardian if the patient has been declared incompetent. (This form need **not** be completed if photographing and/or videotaping is **incidental to a surgical or medical procedure** and the General Informed Consent Form, which contains and authorizations paragraph, is completed.)