

Martin Luther Campus/Ebenezer Resident/Tenant Authorization for Photography, Filming and Interviewing

Name: _____ Date of birth: _____ Phone: _____

I consent to be: Photographed Videotaped Broadcast via secured electronic means
 Interviewed Other: _____

Site name:

My consent will expire after _____ years (1-99 years).

Purpose of use/disclosure:

- Publication in newspaper(s), magazine(s) or other similar publications
- Broadcast by radio, television, Internet, organizational intranet
- Marketing and public relations materials of all of the following; or only
- Publication in professional journals and/or medical books

Please do not disclose my:

- Name
- Date of birth
- Age
- City of residence

_____ (other information)

- I can refuse to sign this form. If I don't sign it, this will not affect my care or payment for my care.
- I agree to this freely, as long as efforts are made to protect my identity (if noted above).
- I know that my recorded information may be used in many ways. This includes fund-raising, marketing, education and other purposes. I will not be informed when it is used. I will not be asked to approve usage.
- I know that any photos or films are the property of Meadow Woods/Ebenezer/Fairview Health Services
- I can change my mind after signing this form. If I do, I may take back this consent by writing to Meadow Woods/Ebenezer/Fairview. This will not apply to information already released. Meadow Woods/Ebenezer/Fairview cannot prevent a third party from seeing information after it is released.
- I give my consent with the following limits: _____

Signature of resident/tenant or authorized person

(If authorized person is signing, please also print name)

Relationship

(Parent, guardian, power of attorney, etc.)

Date / Time

RESIDENT/TENANT AUTHORIZATION FOR PHOTOGRAPHY, FILMING OR INTERVIEWING