United Musculoskeletal Partners

Patient Authorization to be Photographed and/or Interviewed Authorization:

By signing below, I hereby authorize United Musculoskeletal Partners and its affiliated facilities, agents, contractors, providers or associates to interview and/or take photographs of me. I understand that the photograph may include, but not be limited to, videotape, digital image and any other mechanical means of recording or producing visual images. I also understand the interview session may involve, but not be limited to, audio tape, or other recording device, written recording or other mechanical means or medium to preserve the discussions (hereinafter referred to as interview material). I understand and agree that the photographs and/or interview material may also be used and/or disclosed for any and all other purposes deemed appropriate by, United Musculoskeletal Partners and its affiliated facilities, agents, contractors, providers or associates. Such purposes may include, but not be limited to, education, treatment, internal marketing (for example, photo displays within the facility), public relations, advertising, communication materials, promotional and marketing publications (including postings on an organization's website), and/or fundraising activities.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment in any health plan, or eligibility for benefits. I understand that I may revoke this authorization at any time in writing by contacting the marketing department at United Musculoskeletal Partners. I agree to hold United Musculoskeletal Partners and its affiliates, agents, officers, contractors, providers, directors, and associates, or designated third parties who are involved in the production, duplication, publication or any other use and/or disclosure of the photographs, and/or interview material harmless for any damages incurred by such use and/or disclosure of the photographs and/or interview material. I also understand that the photographs and/or interview material used and/or disclosed pursuant to this authorization may be re-disclosed by a recipient and can no longer be protected by the aforementioned parties.

Participant's initials: _____

Signature: _____

Date: _____

Patient (Parent or Legal Guardian)
Name of individual signing on behalf of patient:

_____