



Grady Memorial Hospital

CONSENT FOR PHOTOGRAPHY/VIDEOGRAPHY

I, _____, hereby grant permission for the Grady Health System® to permit a photographer to take photographs, video or otherwise, of me on the premises of the Grady Health System®.

I hereby release the Grady Memorial Hospital Corporation and its employees or agents from any liability arising out of the presence of photographing personnel on the premises of the Grady Health System® and any liability arising from the use of such photographs/videotape.

If the photographs/videotape is to be used for clinical or teaching purposes, I understand that the photographs/videotape shall be the property of the Grady Health System®. Unless I expressly consent otherwise, I understand that the videotape will be used only for the below listed designated purposes:

Signature of parent or guardian

Date

Witness

Date

Witness (second witness required only for telephone consent)

Date