Texas Tech University Health Sciences Center
Ambulatory Clinic

Patient Name
Medical Record #
DOB
(or label)

CONSENT TO AUDIOVISUAL RECORDINGS

Date: _____Time_____

I, _____, hereby consent to the taking of:
(Name)

☐ 1. Still Photographs

☐ 2. Motion Pictures

☐ 3. Video Tapes

☐ 4. Closed Circuit Televising

by the staff of Texas Tech University Health Sciences Center Ambulatory Clinic at the request of Dr. _____, Department of _____.

I understand that any or all parts of my (his/her) body may be included in these visual displays. I further understand that this permission includes visual recording of surgical procedures.

I understand that these photographs, motion pictures and/or video tapes are being made for educational purposes. These visual displays may be published in professional journals and/or medical books; published or used for any other purpose which is deemed fit in the interest of medical education or knowledge, regardless of whether such use of publication is under philanthropic, commercial, institutional or private sponsorship, and irrespective of whether a fee of admission or film rental is charged.

I also consent to preparation of and publication of audio or visual test stating the details of my (his/her) case to accompany the photographs, motion pictures and/or video tapes.

I waive all rights that I may have to claims for payments of royalties or other compensation in connection with the publication of these visual displays and/or with the exhibition and showing of these motion picture films and/or video tapes and the accompanying test.

I further understand that the photographs, prints, negatives and tapes are the property of Texas Tech University Health Sciences Center and may or may not be a part of the clinic records and further, I relinquish any right to inspect them.

I give this consent voluntarily, subject only to the condition that I (he/she) will not be identified by name in connection with the visual displays or in the accompanying text.

This permission does not extend to photographs to be taken by representative of the news media.

This form is **optional** and I understand that **I do not have to sign it** to receive medical care.

_____ _____
Signature of Patient or Authorized Representative Relationship if other than self

_____
Witness