

# MARKETING CONSENT FOR PHOTOGRAPH, VIDEO, AUDIO RECORDING AND/OR INTERVIEW



(Note: For non-Marketing photo consents, use Medical Center Consent Form #030664, CONSENT TO PHOTOGRAPH AND/OR VIDEO.)

I have been asked if I am willing to be photographed, videoed and/or interviewed, and I am a:

- Patient     Minor patient's parent or legal guardian, consenting on behalf of the patient     Family/friend/visitor     UVA employee or volunteer

Check either A or B below or both, as appropriate:

**A** I consent to photographs, videos, audio recordings and interviews of myself or my minor child,

← Print Full Name

and their use to promote the services of UVA Health System and its affiliated organizations.

(Interviews may include the use of any electronic or audio recording media.)

I authorize the use of the photographs/videos/audio recordings/interviews for all the following purposes:

- Advertising (TV, radio, print, billboards, posters, magazine articles, online)
- Social media postings (Facebook, blog)
- News media
- External or internal UVA Strategic Relations and Marketing publications or presentations (e.g., Vim & Vigor, Club Red, Connect, digital media)

I understand that I have the right to withdraw my consent at any time before or during the production of my photograph, video or interview session with a **UVA Strategic Relations and Marketing representative**, and that any photos, videos, audio recordings or interview materials already recorded will be discarded.

**B** I consent for

← (care provider's name or names)

to discuss my or my minor child's medical condition and treatments provided during my/my child's care, with UVA Health System representatives and/or non-UVA persons (e.g., news media), for promotion of services of UVA Health System and its affiliated organizations.

Name of non-UVA person or organization: \_\_\_\_\_

I understand that I have the right to withdraw my consent before my or my child's care provider's discussion with UVA Health System representatives or non-UVA persons, by writing to UVA Health System, Strategic Relations and Marketing, ATTN Traffic/Production, PO Box 800224, Charlottesville, VA 22908-0224.

- I understand that I also have the right to withdraw either of the above consents at any time before UVA Health System uses or discloses my or my child's photograph/video or interview information or information provided in a discussion with my or my child's care provider, by contacting in writing: UVA Health System, Strategic Relations and Marketing, ATTN Traffic/Production, PO Box 800224, Charlottesville, VA 22908-0224.
- If I am a patient or the parent or guardian of the patient, I understand that the patient's medical care is not dependent upon my signing these consents.
- If I am a patient or the parent or guardian of the patient, I understand that these consents do not release me from my financial obligations with UVA Health System.
- Photographs, videos and/or interviews taken by UVA and information provided to UVA representatives by care provider(s) will be stored by the UVA Health System Strategic Relations and Marketing department and will be destroyed when no longer needed. These consents will expire in 25 years.
- I understand that UVA has no control over use of interviews and footage or information taken by or provided to external news media, or posted on their social media. I also understand that if patient photos, videos or other images or patient information are disclosed outside UVA Medical Center, they may no longer be protected by federal privacy laws.

**SIGNATURE:** By signing below, I state that I am 18 years of age or older or that I am the parent or legal guardian of the minor patient named above. I have read or have had explained to me the contents of this form. I have had a chance to ask questions and all of my questions have been answered.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Address of Person in Photograph/Video/Interview

\_\_\_\_\_  
Date and Time

**UVA STRATEGIC RELATIONS AND MARKETING REPRESENTATIVE SIGNATURE:** I have explained the information stated on this form. The person giving consent has communicated to me that they understand the contents of this form. **TELEPHONE CONSENT IS NOT ACCEPTABLE.**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date and Time

**INTERPRETER ATTESTATION:** Interpretation has been provided by:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature of Interpreter/Cypracom ID #

\_\_\_\_\_  
Date and Time