



State University of New York
Upstate Medical University
PHOTOGRAPH/IMAGES CONSENT FORM

I hereby authorize the State University of New York Upstate Medical University and University Hospital to:

- Take and use still or video photographs/images of myself/my child either in conjunction with or without my name/my child's name for publicity. I understand that these photographs/images may be used in newspapers, magazines, publications, advertisements and on television and the world wide web.
- Take and use still or video photographs/images of myself—either in conjunction with or without my name for use in medical teaching purposes or in medical or scientific publications.
- I waive any rights I may have in such photographs/images, as well as the privilege of inspecting or approving them for determining their final disposition.
- Allow Upstate Medical University to take a picture of me/ my child and further it is my understanding that my physician has stated that this is permissible. It is my understanding that also the State University of New York Upstate Medical University and University Hospital is merely acting as a liaison and that this is a matter between the _____ and myself.

TODAY'S DATE

PRINT NAME OF SUBJECT*

JOB TITLE OR STUDENT STATUS
(IF APPROPRIATE)

SIGNATURE OF SUBJECT (Need parent or guardian signature if subject is a minor)

PRINT NAME OF PARENT OR GUARDIAN (if subject is a minor)

ADDRESS

CITY/STATE/ZIP

TELEPHONE(S)

SIGNATURE OF WITNESS

DATE WITNESS

*IF MINOR, SIGNATURE OF PARENT OR GUARDIAN REQUIRED

IF LARGE GROUP SHOT, PLEASE GIVE
A BRIEF DESCRIPTION OF YOURSELF:

HAIR COLOR: _____

CLOTHING: _____

