Duke University
School of Nursing

PLEASE PRINT
Participants Name: _____
Address: _____
_____
Email: _____

AUTHORIZATION FOR RELEASE OF PHOTO/VIDEO/AUDIO

If you choose to participate by being photographed, videotaped or audio taped, you or your dependent released to the media for marketing/advertising purpose, please complete the appropriate paragraph(s) below.

- **Permission for Photographs/Videotaping**
  I, _____ authorize Duke to permit its representatives and/or the news media to take photographs or video tape of me or my dependent _____. I understand that Duke retains no control of the use of any photograph or videotape that is released to or taken by the news media. Expiration date: 100 years from today's date.

- **Permission for Audiotaping**
  I, _____authorize Duke to audio tape or permit the news media to record audio tape of me or my dependent, _____ for use in marketing or advertising purposes. I understand that Duke retains no control of the use of any audio recording that is released to or made by the news media. Expiration date: 100 years from today's date.

- **Permission for Release of Information for Marketing/Advertising Purposes**
  I, _____ authorize Duke to release information and/or take photographs of me or my dependent, _____ for use in marketing or advertising its services. I understand that the information, photographs, videotape or audiotape will be used primarily for marketing or advertising purposes, such as brochures, newsletters, Duke Web site and advertising. Expiration date: 100 years from today's date.

- **Permission for Photography/Videography for Medical Education/Medical Illustration**
  I, _____ authorize Duke to photograph or videotape me or my dependent, _____. I understand the photographs or videotape may be used in any manner considered proper by the Duke administration but will be used primarily for information purposes, medical education or medical illustration. Expiration date: 100 years from today's date.

I understand that:

If the materials are copyrighted by Duke, the material will be under the control of Duke. I understand, however, that once information and/or materials are released to the public information media – including but not limited to television, newspaper, magazine, radio and the internet – Duke no longer has control over their use.

I hereby release and discharge Duke as well as their assigns and/or representatives from any and all claims and demands arising out of or in connection with the use of the photographs, videotape, audiotape and/or release of protected health information.

I will receive no compensation for consent for the release of this material. I also understand that participating in this project will not in any way affect the care I (he/she) received(s) or our medical bills through Duke.

I have read this form and fully understand the contents. I agree to be bound by this consent form. I acknowledge and represent that I am 18 years of age or older and have the right to contract in my own name or that I am legally authorized to sign this form for the participant.

I have the right not to be photographed, videotaped or audio taped or have any information of me or my dependent released to the media. Choosing not to participate, will in no way compromise the care I receive.

This authorization may be revoked at any time. Revocation must be made in writing and sent to the Duke University School of Nursing, DUMC Box 3322, Durham, NC 27710 or faxed to (919)668-3581. Such revocation shall not affect disclosures prior to revocation. I understand that Duke retains no control of the use of this information once it is released to the media.

_____ _____
WITNESS SIGNATURE

_____ _____
DATE RELATIONSHIP