McGill

Centre for Continuing Health Professional Education

Patient's Authorization for Photography, Movies, Recordings and Live Demonstrations

Date: _____ Recording Date: _____

Patient Name: _____

Address: _____

_____

Responsible/ Guarantor: _____

Attending Physician: _____

Address: _____

_____

I, _____, hereby authorize
(Patient's Name - print name clearly)

Dr. _____, holder of license _____, attending
(Physician's Name - print name clearly)

physician of Hospital _____, to use any:

☐ Photographs

☐ Movies

☐ Demonstrations

☐ Tape-recording

That the physician deems appropriate and to utilize and publish them for medical, scientific and educational purposes, including the archiving of such materials in the CHPE website, provided that reasonable precautions be taken to conserve anonymity. In case of live demonstrations, I understand that anonymity may be compromised and still give consent that the material may be used for the reasons hereby described for the following presentation "_____"

dated _____, as part of the _____.

I do, however, make the following restriction(s):

_____

_____

_____

_____ _____
(Patient's Signature or Guarantor) DATE

_____ _____
(Witness's Signature) DATE