AUTHORIZATION FOR USE OF PATIENT PHOTOGRAPHS, IMAGING STUDIES AND/OR VIDEO FOOTAGE

Patient Name _____ Date of Birth_____

Address _____ _____ _____ _____
Street City State Zip code

I consent to the taking of photographs, CT scans, MRI, ultrasound, EEG and/or video footage ("Images") by **New Jersey Pediatric Neuroscience Institute (NJPNI)** or their designee, or parts of my face and body, in connection with the neurosurgical procedure(s) discussed with and/or performed by NJPNI. I understand that such Images shall become the property of NJPNI and may be retained, released or used by NJPNI for the purpose of including them in any print, visual or electronic media, specifically including, but not limited to, websites, social media sites and applications, medical journals and books, for the purpose of informing the medical profession and/or the general public about neurosurgical procedures and methods. In addition, I specifically authorize NJPNI to use this data for the purpose of including them in any print, visual or electronic media, specifically including, but not limited to, websites, social media sites and applications, medical journals and books, for the purpose of advertising.

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding the privacy of my protected health information. I have received, read and understand these rights as described in the Notice of Privacy Practices. I understand that while I will not be identified by name in any publication, in some circumstances, the Images may portray features that will make my identity recognizable. I therefore waive my protected health information rights as they apply to these Images.

I provide this authorization as a voluntary decision. I understand that I may refuse to authorize the release of any protected health information and that my refusal to consent to the release of this information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from New Jersey Pediatric Neuroscience Institute. I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken prior to my revocation.

I release and discharge New Jersey Pediatric Neuroscience Institute (NJPNI) and all parties acting under its license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the Images.

I certify that I have read the above Authorization and Release and that I fully understand and voluntarily consent to its terms.

_____ _____
Patient Signature **Date**

I am the parent, guardian, or legal representative of the above-named patient. I have read the above Authorization and Release and I am authorized to sign this document on his/her behalf. I give this authorization voluntarily.

_____ _____
Parent/Guardian Signature **Date**