Faculty, Staff, Resident, Fellow, Student, Volunteer, Alumni, Visitor, Patient, Patient's Family

UCSF Fresno Photography/Media Consent Release for Media/Public Relations/Educational Purposes

UCSF Fresno Center for Medical Education and Research
155 North Fresno Street, Fresno, CA 93701

Authorization and Consent to Photograph, Publish and Release Information

I, (name) ____(title/position)______________________________ authorize The Regents of the University of California ("University"), including UCSF Medical Center/UCSF Children's Hospital ("Medical Center"), UCSF Fresno, their officers, agents, employees, students and affiliates to take photographs of me, to interview me, to publish, print and broadcast my voice and image, and to authorize other persons to do the same. I understand that my identity may be revealed through my photographs and/or through the use of my name and voice.

☐ I agree that the University may use, and authorize others to use, my name, voice and image for web, public relations and news media purposes, such as for newspapers, web or news television programs, social media and for educational or research purposes such as to illustrate medical lectures.

My permission is subject to the following limitations:

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IN ALL CASES

I waive any right to compensation. I hold The Regents and their designees harmless from and against any claim for injury and or compensation resulting from the activities authorized by this agreement.

The term "photograph," as used in this agreement shall mean motion picture or still photography in any format, as well as videotape/disc, digital media, web and any other means of recording and reproducing visual images and sound.

Check one: ☐ Faculty ☐ Staff ☐ Resident/Fellow ☐ Student ☐ Volunteer ☐ Visitor ☐ Alumni

☐ Patient ☐ Patient's Family Member ☐ Other____________________________

Date: ____

Print Name: ______________________________________ Signature:____

If subject/patient is under the age of 18, parent or legal guardian authorization is required below

Print Name: ______________________________________ Signature:____

Relationship to Patient____

ADDRESS:

____

City/State/Zip ____ Telephone: (_______)__________________________

Witness (if unable to sign):

Print Name: ______________________________________ Signature:____