



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:

\_\_\_\_\_  
\_\_\_\_\_

#### 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: \_\_\_\_\_