Permission for Photography/Video-Recording/Audio Recording

I, ____________________________, hereby authorize Duke University Health System and the Department of Clinical Education and Professional Development to photograph, video-record and/or audio-record me.

I understand the photographs, video-recordings, and/or audio-recordings may be used in any manner considered proper by Duke University administration or staff.

The images, sounds, and/or information obtained by Duke may be edited and/or transferred to any other media (such as the web, CD-ROMs, film or print media) without inspection or approval, on my part, of the finished product or the specific use to which this material may be applied.

The images and/or information obtained by Duke shall become the property of Duke University and may be marketed for any purposes whatsoever. Such publishing and marketing may be done by Duke University and/or by other publishers and/or professional organizations without inspection or approval, on my part, of the finished product or the specific use to which this material may be applied.

The images and/or information obtained by Duke may be used for promotional purposes and/or for education of the public through any media format, including DVD or CD-distribution, public or private broadcasting, newspapers, magazines, and/or the internet. 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, Duke no longer has control over their use.

I understand that I may not receive compensation for appearing in this material and for my consent for the release of this material. I know that I have the right not to be photographed, video-recorded, and/or audio-recorded. 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, video-recordings, and/or audio-recordings, including any associated release of protected health information which is evident in the material.

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.

__________________________________________   ____________________________
SIGNATURE                                      Date

__________________________________________   ____________________________
Printed Name                                  E-mail or phone contact info

Rev 1/2018