



PATIENT CONSENT FORM

*I hereby give permission to Auburn Memorial Hospital and/or _____
_____ (name of media outlet involved) to publish the photograph or
video and/or recording of _____ (patient name)
for promotion of the hospital or news coverage of health-related issues. I under-
stand that this photograph/video/recording will be seen by the public.*

*I understand that I have the right to request cessation of recording or filming at any
point.*

*I understand that I may rescind consent for use of this recording or film up until a
reasonable time before the recording or film is used.*

Signed:

Patient or Guardian

Date

