Mount Sinai

Patient Label

Consent to Use Sound and Image Recordings That May Contain Identifying Information for Education

I _____ (Patient Name) authorize my physician or designee _____ (Name of Physician or Designee) to use images and sound recordings of me taken during the course of my care for educational purposes that may include presentations or publications in textbooks, journals, and electronic formats.

I understand that not authorizing or withdrawal of my authorization to the sharing of images and sound recordings will in no way affect the medical care I receive. If I have any questions or wish to withdraw my authorization in the future, I may contact my provider.

I understand I may withdraw this authorization at any time, and that it will apply going forward; it will not apply to images and sound recordings that have already been shared.

I understand that these images and sound recordings may be seen or heard by the general public in addition to scientists and medical researchers who regularly use these publications in their education.

I understand that these images and sound recordings may have identifying information and that it is possible that someone may recognize me.

I understand that I will not receive payment from any parties for the use of my images and sound recordings.

This consent form applies to all images and sound recordings unless specified below.

- Taken on this date: _____
- Of this part of my body: _____
- For use by the following provider(s): _____
- Other: _____

By signing this form below, I confirm that the contents of this form have been fully explained to me and that I have had an opportunity to have my questions answered.

Patient* or Legally Authorized Representative**

Print Name	Signature	Date	Time	Relationship

Signature Witness

Print Name	Signature	Date	Time	☐ Witnessed patient confirming signature (check box if applicable)

Preferred Language Interpreter Name or Number

Print name and/or number	Signature (if present)	Date	Time	☐ Patient refused interpreter (check box if applicable)

☐ **Telephone/Video Consent (Check box if applicable), Legally Authorized Representative**/Interpreter signature not required.**

Print Name	Attending Physician/Privileged Provider Signature	Date	Time

* The signature of the patient must be obtained unless the patient is under the age of 18 years old or lacks capacity.
** Court appointed guardian, Health Care Proxy, or Surrogate under the Family Health Care Decisions Act.