Penn Medicine

CONSENT TO RECORD AND RELEASE

Name: _____

Address: _____

Phone Number: _____

Date of Birth: _____

I give permission to the agents, assigns, and employees of the University of Pennsylvania Health System and the Perelman School of Medicine (collectively "Penn Medicine") to photograph, videotape, audiotape or otherwise make recordings of my image and/or voice in any medium (collectively referred to as "Recordings") for the following purposes:

Check all that apply and describe in detail the specific purpose(s):

- ☐ Education Purposes: _____
- ☐ Marketing and Publicity: _____
- ☐ Public Affairs: _____
- ☐ Development and Fundraising: _____
- ☐ Research Activities: _____
- ☐ Other: _____

I understand that I may revoke this consent in writing at any time, and if I do so Recordings will cease to be taken. Such revocation, however, will have no effect on Recordings already taken to the extent we have relied on the consent.

I agree and understand that Recordings will be the property of Penn Medicine. I also agree that the personal satisfaction derived from my cooperation in furthering the health, education, and research objectives of Penn Medicine is sufficient consideration for the activities authorized hereunder, and I waive any payments, royalties or other compensation.

I release the agents, assigns, employees, and hospitals of Penn Medicine from any claims and any liability arising in connection with the taking, use, or distribution of any Recordings made pursuant to this consent.

I understand that the publication and/or distribution of Recordings may require me to complete an Authorization for Use and/or Disclosure of Protected Health Information including Recordings.

I give this consent voluntarily and with full understanding of its nature.

_____ _____

Signature of Person Being Recorded Date