1. I, ______________________________________, agree to participate in an interview and the allow use of the information obtained for the following purpose: ____________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

2. I, _______________________________________, authorize the Virginia Commonwealth University Health System (VCUHS) to use photographic, digital or video images of me for the following specific purpose:
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

3. VCUHS has explained to me that the photographic, digital or video images of me will only be used for the purpose stated above. I understand that I will not receive compensation in exchange for the use of the photographic, digital or video images.

4. I have had the opportunity to ask questions about the purpose for which, and about the manner in which, the photographic, digital or video images will be used, and all my questions have been answered satisfactorily. I hereby release and hold harmless VCUHS, the Medical College of Virginia Hospitals and Physicians, and their respective officers, employees and agents from liability for any claim I have, or might ever have, in connection with the use of the photographic, digital or video images.

5. I understand that I may refuse to sign this Authorization. If I choose not to sign, my treatment will not be affected in any way.

6. I understand that information used or disclosed under this Authorization might be re-disclosed by a recipient and may, as a result, no longer be protected to the same extent it is protected while in the possession of VCUHS.

7. This Authorization is subject to revocation in writing at any time except to the extent that VCUHS has already taken action in reliance on it. I may revoke the Authorization by written notification to the following ______________________ at VCUHS.

   (Person Obtaining Authorization)

If not previously revoked, this Authorization will terminate upon: _____________________________________
   ______________________                          ______________________
   (specific date, event or condition)

Signature of Patient or Legal Representative
   ______________________
   ______________________
   ______________________
   ______________________
   ______________________

Person Obtaining Authorization Signature
   ______________________
   ______________________
   ______________________
   ______________________
   ______________________

Printed Name/ Title
   ______________________
   ______________________
   ______________________
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Date
   ______________________
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Time
   ______________________
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Signature
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Witness Signature
   ______________________
   ______________________
   ______________________
   ______________________
   ______________________

Printed Name/ Title
   ______________________
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Date
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Time
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   ______________________