Creighton
THERAPY AND WELLNESS

AUTHORIZATION FOR USE OF PHOTOGRAPHS

By my signature below, I authorize Creighton University to use my video image (whether film, video, or digital), as indicated below.

The video, including audio and images, will remain the possession of Creighton University. I understand that the video, as well as pertinent information and quoted statements, will be used in a health education program to be taught at Creighton University. My name will not be used in the class.

The video will not become part of my medical record at Creighton.

This authorization will expire upon termination of health education program.

I understand that I may withdraw this authorization at any time. My withdrawal must be made in writing and addressed to: *Creighton University, Attn: University Privacy Officer, 2500 California, Omaha, NE 68178.*

I understand my written withdrawal will not be effective to the extent that Creighton University has already acted in reliance on this Authorization.

_____ _____

Signature of patient/authorized representative Date

_____ _____

Patient Name (please print) Date of Birth