UConn Health Center

Authorization to Photograph/Video/Audiotape

I hereby authorize the taking of photographs, movie film, videotape or audiotape of:

1. **Self** (name) _____
2. **And/or** (name/relationship: i.e. child's name, parent's name)_____
3. **By** (list name OR dept. phone # contact)_____
4. **For the project**: Changing Oral Health Norms and Hygiene Practices among Vulnerable Older Adults

For one or more of the following purposes (check as appropriate and cross out the rest).

5. ☐ **Public Information.** I understand this means use on television or on radio, in newspapers, magazines, brochures, other promotional or patient education materials, exhibits or Health Center publications including Health Center websites and that the person or I named above may be identified.

6. **X Medical Study or Research.** I understand this means use in teaching or to illustrate research work and that there will be the following safeguards. Please indicate your preference to the questions below by checking the appropriate box:
   a. My name or the name of the person shown above:
      ☐ May be listed as a contributor to the materials developed.
      ☐ May NOT be listed as a contributor to the materials developed.
      ☐ May be identified by voice and/or text in the materials developed.
      ☐ May NOT be identified by voice and/or text in the materials developed.
   b. ☐ I wish to act on my right to approve the materials developed in final form. I have received a copy of this form along with department/person contact information.
      ☐ I do NOT wish to approve the final materials developed.
   c. Upon my request, the photographs, movie film, videotape or audiotape, including all copies, prints and negatives will be destroyed.
   d. If the purpose is for Mental Health, I understand that exclusively mental health professionals will use it only for instructional purposes noted above in line 4.
   e. The material will be kept confidential within the parameters I've noted above.

7. ☐ **Personal Reasons.** This means the photograph, film, videotape or audiotape is being taken at my request for my personal use.

I have been informed of the intended use. I further understand that I may withdraw this authorization at any time by written request. This Authorization does not have an expiration date. However, if you sign this authorization you can still change your mind at a later date. You can revoke this authorization by sending a written notice to Susan Reisine, UCHC, 263 Farmington Ave, MC3910, Farmington, CT, 06030, to inform her of your decision. I further understand that I do not have to sign this authorization to ensure my continued treatment.

_____ _____
Name of person authorizing: (Signature) (Printed name)

_____
Address

_____ _____
Address Date signed

_____ _____
Witnessed by Date

Original copy - Chart Copy - Patient