UCLA Health

MRN:
Patient Name:

(Patient Label)

CONSENT TO PARTICIPATE IN MEDIA | MARKETING ACTIVITIES
(ADULTS, MINORS AND WARDS)

PARTICIPANT TYPE

☐ Patient ☐ Other:_____

Participant's Name:_____ Date of Birth:____/____/_____

Address (City, State, Zip):_____

Phone Number: (____)_____ E-mail (optional):_____

ACTIVITY (check all that apply)**:**

☐ Interview ☐ Photography ☐ Audio Recording ☐ Filming or Video Recording

☐ Other:_____

TYPE OF USE:

☐ By a UCLA Health representative ☐ Other:_____

Description:_____

UCLA Health Department:_____

FOR FUTURE PROJECTS, I AUTHORIZE THE FOLLOWING (please select one**):**

☐ UCLA may reuse the participant's image or likeness for other projects (Initial:_____)
☐ UCLA must request consent before reusing the participant's image or likeness for other projects (Initial:_____)

I understand that this authorization is voluntary. If the participant is a patient of UCLA Health, I understand that their ability to receive health care services, eligibility for benefits, or reimbursement for services is not conditioned on the signing of this authorization.

I understand that all negatives, prints, digital reproductions, recordings, and videotapes shall be the property of UCLA and shall not be returned to me or the participant.

I may cancel or revoke my authorization at any time by writing to:

UCLAHealthNews@mednet.ucla.edu
OR
UCLA Health Media Relations
10960 Wilshire Blvd., Suite 1955
Los Angeles, CA 90025

Revocation will be effective upon receipt, except to the extent that UCLA or others have already relied on it. If the multimedia items have already been shared, it may not be possible to recall them.

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I have read this form, and all of my questions have been answered. I hereby agree to release UCLA and those acting pursuant to their respective authority from liability for any violation of any personal or proprietary right I, or the participant, may have in connection with the use of the participant's image or likeness for the activity described above.

Signature of patient, parent or conservator _____ Date _____ Time _____

If not signed by patient, indicate relationship or guardian: _____

UCLA Representative Name _____ UCLA Representative Signature _____

Date _____ Time _____

I have accurately and completely read this consent to (patient or patient's legal representative) in the patient's or legal representative's primary language _____ (identify language). He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

Signature of Translator _____ Printed Name of Translator _____

Date _____ Time _____ Translator ID # _____