Alberta Health Services

# Consent To Collect, Use, and Disclose Stories, Photos and/or Video and Sound Recordings

***Important*** - Complete this form when a photo, audio, video or written recording is needed for media, promotions, publications, education, presentations and other similar purposes.

| Name of Individual being recorded | | | | |
|---|---|---|---|---|
| Address | City/Town | Prov | Postal Code | Phone Number |
| Name of Individual giving consent *(Individual or Authorized Representative)*<br>☐ Self | | | Source of Representative's Authority<br>*(Attach a copy of the document which authorizes you)* | |

Type of recording *(check all that apply)*

☐ Still/Digital Photographs ☐ Sound Recordings ☐ Video Recordings *(with or without sound)*
☐ Interviews/Writing/Stories/Narratives ☐ Other, specify _____

Scope of Use or Disclosure ☐ Internal only ☐ Both internal and external to AHS

Purpose of collection and disclosure

☐ Media Release/Interviews ☐ AHS Publications ☐ Quality Improvement
☐ Promotions ☐ AHS or Hospital Presentations/Displays ☐ Quality and Patient Safety Reporting
☐ AHS Education ☐ AHS Website
☐ Other, specify _____

Name of person or group the recording, story or photo is being shared with *(For example "The General Public", "Research Papers", "AHS Website")*

_____

- I authorize Alberta Health Services (AHS) to record me and/or take my photo and use them in communications about AHS programs and services. I understand there are many ways of sharing communication, including printed and electronic methods. I understand that the recording or photo may be shared with a range of people and groups.
- I authorize AHS to use my name, address and telephone number to contact me about this consent.
- I understand why these recordings and/or photos are being taken and how they may be used. I know that there are risks and benefits to giving this consent. I know that I can stop this consent at any time by informing AHS in writing.
- I understand that AHS cannot control information once it has been shared outside of AHS. I understand that if I ask AHS to stop using my recordings and/or photos it will only stop *additional* use of those recordings and/or photos after the date my request is received by AHS.
- I agree to release and discharge AHS and those that AHS is responsible for at law from the responsibility and liability of the content and claims for the printed/electronic communication where my information was used. I confirm that this release and discharge shall be binding upon my heirs, executors, administrators and assigns.

| Date consent is effective *(yyyy-Mon-dd)* | Expiry date *(yyyy-Mon-dd)*<br>☐ None |
|---|---|
| Signature of Individual/Authorized representative giving consent | Date *(yyyy-Mon-dd)* |

**Witness:** I watched the Individual giving consent sign the consent form *(witness must be at least 18 years of age)*

| Name | Signature | Date *(yyyy-Mon-dd)* |
|---|---|---|
| | | |

*The information on this form, together with any record authorizing a representative to act on behalf on the individual, is being collected under section 22 (3) and 23 of the Health Information Act and/or section 33(c) of the Freedom of Information and Protection of Privacy Act for the purpose of recording consent to the disclosure of health information and/or personal information in the specified recording. Information collected on this form will be retained in the client file. For questions about the collection of your information please contact the Communications Advisor working with you or call 403-943-1210.*