Delta
SPINE AND PAIN CLINIC

USE/CAPTURE OF IMAGE AND VIDEO CONSENT FORM

Name of Patient: _____

I, the patient, hereby give consent to Delta Spine and Pain Clinic and/or other parties authorized by Delta Spine and Pain Clinic to perform image capturing and its use as outlined below.

☐ Do agree ☐ Do not agree	To the use of picture capturing devices for capturing still or moving images (i.e. X-ray, fluoroscopy, camera, video camera, etc.)
☐ Do agree ☐ Do not agree	To use the images/photographs for education (ex. Training/teaching)
☐Do agree ☐Do not agree	To use the images/photographs for publications
☐Do agree ☐Do not agree	To use the images/photographs for marketing or broadcasting

I understand that my medical information will not be disclosed unless directed by me or when required by law. I understand that by signing the consent, I am authorizing Delta Spine and Pain Clinic and its associates or other authorized parties to use my photographs, images or recordings.

I hereby waive any compensation for the use of photographs, images or recordings obtained, and I release any authorized representatives of media, agents or representatives, doctors, healthcare providers, and employees from any and all claims, demands, liabilities, and actions, causes of action, suits, and costs whatsoever that I/we may have against any of them in connection with the capturing and use of photographs, images or recordings.

By signing below, I confirm the comprehension of the consent form and agree as above.

_____ _____

Patient's Signature (Person authorized to sign for the patient) Date

_____ _____

Witness Date