Community Memorial Healthcenter / CMH Surgical Services, LLC
Patient Photograph Release

Patient's Name_____

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of the CMH/CMH Surgical Services, LLC staff. I hereby give my consent for CMH/CMH Surgical Services, LLC to use the photographs under one of the following circumstances:

Please initial ONE of the following:

ALL MEDIA

_____Photographs taken of me or parts of my body as well as details regarding medical services I have received at CMH/CMH Surgical Services, LLC may be used in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, our internet site and television, in order to inform the public about surgery methods. Further, I release and discharge CMH/CMH Surgical Services, LLC the facility used, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

WEBSITE ONLY

_____Photographs taken of me or parts of my body as well as details regarding medical services that I have received at CMH/CMH Surgical Services, LLC may be used on our internet website in order to inform the public about surgery methods. Further I release and discharge CMH/CMH Surgical Services, LLC , and employees of CMH/CMH Surgical Services, LLC, any facility used, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

PHOTO ALBUM / OFFICE DISPLAY BOARD ONLY

_____Photographs taken of me or parts of my body as well as details regarding medical services that I have received at CMH/CMH Surgical Services, LLC may be used in the photograph album or display in order to inform other patients of CMH/CMH Surgical Services, LLC about surgery methods. Further I release and discharge CMH/CMH Surgical Services, LLC, and employees of CMH/CMH Surgical Services, LLC, any facility used, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment in connection with any such use or publication in the photograph album. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject to only the condition that I am not identified by name at any time during any use of these materials by any party.

MEDICAL CARE ONLY

_____Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with CMH/CMH Surgical Services, LLC The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at CMH/CMH Surgical Services, LLC.

Date_____ Witness_____

Patient or Guardian Signature_____