

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 <i>(Individual or Authorized Representative)</i> <input type="checkbox"/> Self			Source of Representative's Authority <i>(Attach a copy of the document which authorizes you)</i>	
Type of recording <i>(check all that apply)</i>		<input type="checkbox"/> Still/Digital Photographs		
<input type="checkbox"/> Video Recordings <i>(with or without sound)</i>		<input type="checkbox"/> Sound Recordings		
<input type="checkbox"/> Interviews/Writing/Stories/Narratives		<input type="checkbox"/> Use of Individual's first and last name for accrediting		
<input type="checkbox"/> Other, specify _____				
Scope of Use or Disclosure		<input type="checkbox"/> Internal only <input type="checkbox"/> Both internal and external to AHS		
Purpose of collection and disclosure				
<input type="checkbox"/> Media Release/Interviews		<input type="checkbox"/> AHS Publications		<input type="checkbox"/> Quality Improvement
<input type="checkbox"/> Promotions		<input type="checkbox"/> AHS or Hospital Presentations/Displays		<input type="checkbox"/> Quality and Patient Safety Reporting
<input type="checkbox"/> AHS Education		<input type="checkbox"/> AHS Website		<input type="checkbox"/> Social Media
<input type="checkbox"/> Other, specify _____				
Name of person or group the recording, story or photo is being shared with <i>(For example "The General Public", "Research Papers", "AHS Website")</i>				
<p><input checked="" type="checkbox"/> 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.</p> <p><input checked="" type="checkbox"/> I authorize AHS to use my name, address and telephone number to contact me about this consent.</p> <p><input checked="" type="checkbox"/> 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.</p> <p><input checked="" type="checkbox"/> 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 <i>additional</i> use of those recordings and/or photos after the date my request is received by AHS.</p> <p><input checked="" type="checkbox"/> 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.</p>				
Date consent is effective <i>(dd-Mon-yyyy)</i>			Expiry date <i>(dd-Mon-yyyy)</i> <input type="checkbox"/> None	
Signature of Individual/Authorized representative giving consent			Date <i>(dd-Mon-yyyy)</i>	
Witness: I watched the Individual giving consent sign the consent form <i>(witness must be at least 18 years of age)</i>				
Name		Signature		Date <i>(dd-Mon-yyyy)</i>

The information on this form, together with any record authorizing a representative to act on behalf of 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 email story.hub@ahs.ca.