Medical Patient Story Media Release Consent Form

Patient Information

Full Name:

Date of Birth:

Phone:

Email:

Consent Details

☐ Photographs

☐ Videos

☐ Audio recordings

☐ Written/Verbal Story

Other (please specify):

Purpose of Use

Authorization

I hereby authorize the use of my story and any associated media described above for the purposes outlined in this form. I understand that my information may be used in print, online, and/or other media formats.

Patient/Legal Guardian Signature

_____

Date

If patient is under 18, name of parent/guardian:

Additional Notes: