

OREGON HEALTH SCIENCES UNIVERSITY PERMIT FORM
THIS PERMIT IS VALID UNLESS CONSENT IS REVOKED IN WRITING

(Permit must be signed by parent or guardian if the permission is for a minor or person is not able to sign because of medical condition.)

OHSU includes but is not limited to the Schools of Dentistry, Medicine and Nursing; Biomedical Information Communication Center; Center for Research on Environmental and Occupational Toxicology; Vollum Institute for Biomedical Research; University Hospital and Clinics; Doernbecher Hospital for Children; and Child Development and Rehabilitation Center.

imprint clinic card here if applicable

Date: _____
Location of photo, interview session: _____
Name: _____
Address: _____
Birthdate (optional) _____ Phone: _____

ADDITIONAL INFORMATION FOR MINORS

Parent name: _____
Primary physician: _____
Primary nurse: _____

NON-OHSU:

- radio
 television
 publication
 other _____

OHSU:

- video/audio
 publication
 other _____

PROJECT COORDINATOR:

- OHSU Foundation
 Doernbecher Foundation
 University Communications
 other _____

PUBLICATIONS/MEDIA PERMIT

(Please check information authorized.)

I hereby authorize the release of the following:

- photographs video/audio tapes motion pictures
 my name statements

I hereby authorize OHSU to use and to authorize others to use such information, film, recordings or other transcriptions of conversations without restriction as to time for:

- commercial and non-commercial publications commercial and non-commercial broadcast media
 OHSU publications/videos only other _____

I waive any and all claims I may have or later acquire against OHSU for the use of the information authorized by this document. I understand I may revoke this consent at any time by giving written notice to the project coordinator indicated above.

Witness

Signature

Signature of parent or guardian if a minor or other responsible person if unable to sign because of medical condition (please indicate relationship)

MEDICAL INFORMATION PERMIT

I authorize the release of medical and/or surgical information as well (as patient's name, age, city/state of residence) for _____ in the case of inquiry from media or for OHSU publications/videos.

Name

I further authorize the use of the patient's name in connection with this information. I release Oregon Health Sciences University from any responsibility in this matter. I understand I may revoke this consent at any time.

Witness

Signature

Signature of parent or guardian if a minor or other responsible person if unable to sign because of medical condition (please indicate relationship)

This form should be filed as a permanent part of the patient's medical record; or if not a patient, with project coordinator indicated above. If consent is revoked, please notify the Office of University Communications, mail code 1217.