

## Consent for Release of Video/Picture Footage for Educational and Marketing Purposes

As part of your treatment at Indiana State University Physical Therapy and Sports Rehabilitation, we will be making a photograph and videotape recording of you during your sessions as needed. Please indicate what uses of this photograph/videotape/audiotape you are willing to consent to by initialing below. You are free to initial any number of spaces from none to all of the spaces, and your response will in no way affect your treatment or plan of care. We will only use the photograph/videotape/audiotape in ways that you agree to. In any use of this photograph/videotape/audiotape, your name would not be identified. If you do not initial any of the spaces below, the photograph/videotape/audiotape will be only uploaded to electronic medical record which is protected by the Health Insurance Portability And Accountability Act of 1996 (HIPAA).

Please indicate the type of informed consent

Photograph  Videotape  Audiotape

(AS APPLICABLE)

- The photograph/videotape/audiotape can be studied and published for use in research.

Please initial: \_\_\_\_\_

- The photograph/videotape/audiotape can be shown/played for educational purposes in the classroom setting or continuing education programs at the clinic.

Please initial: \_\_\_\_\_

- The photograph/videotape/audiotape can be used for marketing on handouts, television commercials, etc.

Please initial: \_\_\_\_\_

- The photograph/videotape/audiotape can be used on Facebook or Twitter for marketing, publication of weekly challenges, etc.

Please initial: \_\_\_\_\_

- The photograph/videotape/audiotape can be displayed in the clinic as testimonials.

Please initial: \_\_\_\_\_

I have read the above description and give my consent for the use of the photograph/videotape/audiotape as indicated above.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_