Authorization to Obtain/Utilize Images
It is the policy of the University of Kentucky Chandler Medical Center that informed written consent be granted for all photography and/or videotaping.

I, ____________________________________________, (*) hereby grant permission to the University of Kentucky Chandler Medical Center to photograph and/or videotape me, or my minor child, and/or to supervise any others who may do the photography and/or videotaping for the following project:

___________________________________________________________
(Project Name)

I also authorize the University of Kentucky Chandler Medical Center to use and/or permit others to use the aforementioned images in the following educational, informational and promotional activities without compensation.

___ News Media: ________________________________________________________

___ Institutional Promotion/Advertising: ______________________________________

___ Educational Publications/Videos: __________________________________________

___ Electronic Publishing (e.g. World Wide Web): ________________________________

_____________________________________ ________________________
Signature       Date

_____________________________________ ________________________
Witness Signature     Date

*If the individual to be photographed and/or videotaped is under the age of 18, please indicate your relationship or authority to consent: ____________________________

_____________________________________ ________________________
Signature of Minor       Date