Western HealthSciences

Consent for Photographs, Films & Sound Recordings

I _____ agree to permit [INSTITUTION] in collaboration with the Faculty of Health Sciences at Western University to take, produce, and share the media indicated below of myself:

- Photos - Yes / No
- Films - Yes / No
- Sound recordings - Yes / No
- Radiographs or other medical images – Yes / No
- Other _____

Purpose

The collected media will be added to an Open Education Resource (OER) medical education media library with the intention of supporting the creation of educational materials. The collected media will be made freely available to the public under a Creative Commons Non-Commercial license. This license allows others to use and adapt the media for use in non-commercial works. I further understand that because these materials are made available under a Creative Commons license that UWO is unable to control the use of these materials beyond ensuring that they are not used commercially.

Confidentiality

When publishing this media, I give the following permissions:

1.) Given name and surname may be used _____
2.) Given name only may be used _____
3.) Name may not be used and reasonable steps must be taken to ensure anonymity, including obscuring any identifying features in the media _____

Your Rights

Granting your permission for collection of images, video, audio or other media is entirely voluntary. You may refuse to grant permissions without any penalty or loss of care or services. You have the right to stop the photography, filming or recording at any time.

Revoking Permissions

You may change your mind and withdraw your permission to include the photographs, videos, or other collected media in the OER media library at any time. To revoke your permission, please email healthoer@uwo.ca.

Western HealthSciences

Upon receiving your email, the associated media will immediately be removed from the OER media library. However, we are unable to recall media that has already been used by others or prevent further distribution from others who have already copied the media.

I give permission to [INSTITUTION] and the Faculty of Health Sciences at Western University to collect the media stated above. I understand that the collected media will be added to an open educational resource media library and that these materials will be made publicly available and may be freely copied, edited, distributed, transmitted, published, exhibited or otherwise used for non-commercial purposes. I waive all rights that I may have in the use of my likeness, photograph, voice, or appearance in these multimedia items. I will not receive any payment for any use of them. I have read this consent form, and I understand the permission I am giving. My questions have been answered to my satisfaction. I will get a copy of this form.

_____ _____

Patient Signature Date

If the patient is unable to give consent, please complete the following:

_____ _____ _____

Representative Signature Representative Name Relation to Patient

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_____ _____ _____

Staff Signature Staff Name Staff Role

Unique ID: _____