



Consent for Interviews, Photography, Audiotape, Videotape

Name: _____ Mayo Clinic No: _____

I consent to be interviewed/photographed/audiotaped/videotaped for the purposes of publication, broadcast, medical instruction, sale, or any other use Mayo Medical Center deems appropriate.

I further consent that such information/photography/audiotape/videotape shall be the exclusive property of Mayo Clinic, free and clear of any claim on my part.

I consent to the above without expecting payment, and I release Mayo Medical Center, its corporations, trustees and employees from any and all liabilities which may arise from the use of such information/photography/audiotape/videotape. It is understood that my name/identity may also be used for these purposes.

Patient Signature: _____ Date: _____

If patient is a minor, consent of parent or guardian: _____

Video Production Title: _____