MAYO CLINIC

Consent for Interviews/Photography/ Audiotape/Videotape/Filming

Name(s) _____

I consent to be interviewed/photographed/audiotaped/videotaped/filmed for publication, broadcast, medical instruction, patient education, electronic transmission or any other use Mayo Clinic deems appropriate (including publication in promotional materials to potential Mayo benefactors, Mayo-sponsored Web sites, and public museum-quality displays and exhibits).

☐ Please check here if you do not wish to be featured in Mayo-sponsored Web sites.

I further agree that such information/photography/videotape/film/electronic data 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 or royalties, and I release Mayo Clinic and its employees from any and all liabilities which may arise from the use of such information/ photography/audiotape/videotape/film/electronic data.

It is understood that my name/identity, as well as any other information that I provide, may also be used for these purposes.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature of Parent or Guardian (if under age 18) Date

_____ _____
Mailing Address Daytime Telephone

_____
City, State, ZIP Code

Original - Department of Development *Copy - Participant*