Consent for Photography and Recordings

I authorize my clinician or medical professional, listed below, to use and release information about me, including health information, medical history, diagnoses, medical care, and treatment for the following purposes:

- ☐ Live education and training event(s) hosted by the Functional Neurological Disorder Society.
- ☐ Posting to the Members Only section of the Functional Neurological Disorder Society website for education and training.
- ☐ Potential publication of recordings in a peer review journal (not required for case presentations, but needed if the case is subsequently going to be written up for publication)

I give permission, as selected below, to be photographed, audio recorded, or video recorded (each known as "Recording") during interviews, diagnostic/treatment sessions, surgical/medical procedures, celebrations, or events. I understand that I may be identified from these Recordings and my information will no longer be protected by privacy laws once released.

I am consenting to *(check all that apply)*:

- ☐ Audio Recordings
- ☐ Photographs/Digital Images
- ☐ Video Recordings

☐ I understand and agree that:

- I may refuse to sign this authorization. This will not affect my treatment, payment, health plan enrollment, or eligibility for benefits.
- I grant and release to my care team all rights, title, and interest that I may have in these Recordings, including copyrights in the Recordings, and rights to use, reproduce, modify, create derivative works of, broadcast and distribute the Recordings.
- I will not receive, and I am giving up any claim to receive, payment or royalties in connection with use or disclosure of the Recordings.
- The Recordings may be edited, modified, or retouched for artistic and graphic production reasons or to withhold identity.
- I may cancel this authorization unless if the authorized action has already been taken. I understand my clinician/medical professional cannot get back copies of the Recordings and information once they have been released to third parties, after which, they have no control over how the third parties use, disclose, or protect the Recordings and information.
- This authorization remains in effect until the Recordings and information are no longer needed for the above-indicated purpose(s) unless I specify otherwise in the space below. I understand that third parties cannot be prevented from using them after this authorization has expired. Authorization expires: ___________

I carefully read and understand this form and my questions were answered to my satisfaction. I expressly and voluntarily authorize the use of the Recordings and information as set forth above:

____

Name of Individual | Signature | Date

____

Name of Legally Authorized Representative *(If Applicable)* | Relationship | Signature | Date

____

Name of Clinician/Medical Professional Allowed to Disclose this Information | Signature | Date

PLEASE RETAIN A COPY OF YOUR SIGNED AUTHORIZATION FORM FOR YOUR RECORDS