



# PHOTOGRAPHY / MEDIA CONSENT AND RELEASE FORM

How you want to be treated.

**PHC Communications Department**  
1081 Burrard Street, Vancouver, BC, V6Z 1Y6  
604.806.8022  
communications@providencehealth.bc.ca

- |  |   |
|--|---|
| <input type="checkbox"/> Holy Family Hospital        | <input type="checkbox"/> Youville Residence |
| <input type="checkbox"/> Honoria Conway              | <input type="checkbox"/> Crosstown Clinic   |
| <input type="checkbox"/> Mount Saint Joseph Hospital | <input type="checkbox"/> Brock Fahrni       |
| <input type="checkbox"/> St. Paul's Hospital         | <input type="checkbox"/> Langara            |
| <input type="checkbox"/> Other _____                 |   |

## CONSENT FOR PHOTOGRAPHY (PUBLICITY)

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I hereby consent to being interviewed, photographed and/or videotaped by representatives or agents of Providence Health Care (PHC), or by persons authorized by PHC, for news, publicity or educational purposes.

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Such materials and their copyrights shall be the property of PHC or the specified media organization. I agree to waive any claims I may have to these materials, and release Providence Health Care, its employees, agents and representatives from any liability or claims arising from their use.

I also grant permission for my name to be released in connection with these materials.  Yes  No

\_\_\_\_\_  
Name of Person Consenting (please print)

\_\_\_\_\_  
Witness Signature (PHC representative)

\_\_\_\_\_  
Signature of Person Consenting  
(or parent or legal guardian)

\_\_\_\_\_  
Witness Name & Department (please print)

\_\_\_\_\_  
Location (Hospital / Unit)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Email or Phone of Person Consenting

\_\_\_\_\_  
Media Reference