Lakernick Brain Center, Inc.
Financial Policies
Consent for Video Records

I, ____, give permission to Lakernick Brain Center, Inc. to record (a) video clip(s) and/or photograph(s) of my person during the course of my examination and treatment as a patient.

I give authorization to Lakernick Brain Center, Inc. to disclose the information in the video clip(s) and/or photograph(s) of my person within the constraints of my HIPAA authorization.

I understand that the video clip(s) and/or photograph(s) may be submitted for publication in a peer reviewed medical journal.

I understand that the video clip(s) and/or photograph(s) may eventually be used by the readers of a peer-reviewed medical journal for educational purposes.

I understand that the video clip(s) and/or photograph(s) may eventually be used by students and clinicians for educational purposes.

I agree that there will be no expiration date relating to my consent or the purpose of the use or disclosure.

I understand that I have the right to revoke my consent in writing a t any time.

I understand that the information in the video clip(s) and/or photograph(s) of my person, once disclosed, may be subject to further disclosure by the recipient journal or publication, in which case confidentiality would no longer he assured.

I understand, additionally, that in some cases the video might be re-presented elsewhere because the journal has policies that allow permissions and/or use copyrighted materials with other educational organizations.

I understand that in such a case the signed author's consent form may be shared with a third party and the consenting party consents to this sharing of information for educational purposes

______________________________	______________________
Signature of Patient or Representative	Date
______________________________	______________________
Witness Signature	Date