Instructions:

1. Email the complete form to WVU OHRP at [IRB@mail.wvu.edu](mailto:IRB@mail.wvu.edu)

OR

1. Mail the completed form to the address listed below.

Authorization for Photographs and Publication

**Name of Consenting Individual:** 

**Research Project Title:** 

**WVU Principal Investigator Name:** 

I consent to and authorize West Virginia University (WVU) Board of Governors on behalf of West Virginia University and its principal investigators (PI), employees, representatives, and/or agents to use and/or disclose my (or the patient's) health information obtained in the course of participation in the research project indicated above for media, promotional, fundraising and/or advertising purposes.

In connection therewith, I consent to and authorize WVU and its principal investigators, employees, representatives, and/or agents to engage in the collection of photographs, films, videotapes, recordings, publications, and/or other electronic or non-electronic recordings about me (or the patient if applicable) and to use and/or disseminate these stories, photographs, videos, or depictions in publicizing the work and activities of the research project.

I grant WVU and its principal investigators, employees, representatives, and/or agents' permission to use and/or disclose any materials obtained under this Authorization without limitation in any WVU publication or other broadcasts, print, or electronic media.

This Authorization will expire three (3) years from the date below. I understand that I have the right to stop photography, filming, videotaping, recording, and/or an interview at any time.

I understand that I can revoke this Authorization at any time. To revoke this Authorization, send a request to the WVU Human Research Protection Program, 886 Chestnut Ridge Road, Morgantown, WV 26505. I understand that revocation does not affect disclosures made while the Authorization is in effect.

I understand that my treatment, payment, enrollment, and/or eligibility for health care services will not be contingent upon either this Authorization or revocation of the same.

I understand that this Authorization is voluntary and waive any right to compensation for uses authorized by this Authorization.

I and my successors or assigns hold WVU and its respective directors, officers, members, principal investigators, employees, representatives, personnel, agents and affiliated programs harmless from any and all liability, claims, and/or damages which may or could arise from the activities authorized by this Authorization.

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| Patient, Participant or Representative's Signature |
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| Printed Name |
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| Relationship to Patient |
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| Address |
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| Phone Number |
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| Date |

By signing below, I acknowledge MY UNDERSTANDING and consent to the above statements.

**Indicate the authorized use of photography, recording, or publication:**

News Media Marketing Materials Newsletters

Websites\Social Media Internal Communications Other (specify) 

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| Signature of Witness |
| Printed Name Date |