



Consent to Photograph and/or Videotape

Activity Description:

Start & End Dates:

Name:

Birth Date:

Parent/Guardian (if applicable):

Address:

Phone:

Email:

Participant consents to be:

☐

Photographed

☐

Filmed/Videotaped

☐

None of the foregoing

☐

Other

Purpose of Use/Disclosure:

☐

University of Colorado Denver/Anschutz Medical Campus/Center for Innovative Design and Engineering marketing and public relations materials/publications for print, web, social media and electronic distribution.

☐

University of Colorado Denver/Anschutz Medical Campus/Center for Innovative Design and Engineering to document the progress of treatment.

☐

By University of Colorado Denver/Anschutz Medical Campus/Center for Innovative Design and Engineering for educational materials for course offerings, conferences, publications, etc.

☐

Publication in newspaper(s), magazine(s), or other educational publications.

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Name (REQUIRED. This constitutes a signature.)

Date (REQUIRED)

Parent/Guardian for Minor (REQUIRED IF APPLICABLE.
This Constitutes a signature.)

Date (REQUIRED)

This authorization will expire on the following: (check and complete only one box)

☐ 99 years from date signed

☐ Date: _____

☐ Event: _____

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