CONSENT FOR CLINICAL VIDEO
AND AUDIO RECORDINGS

University of Manitoba

I hereby authorize the Health Sciences Centre and/or University of Manitoba to take video and sound recordings of me. I understand that these video and sound recordings are to be used for medical education as deemed appropriate by the Health Sciences Centre and/or University of Manitoba. I understand that these video and sound recordings will be destroyed or erased after their utility has expired.

I hereby waive any right to inspect or approve the finished product or product that may be used with the video or sound recordings of me.

I understand that I will not be paid for the video and sound recording in which I am a subject.

I hereby waive all claims that I might have against the Health Sciences Centre and/or University of Manitoba, its employees and agents, in any manner whatsoever relating to the said video and sound recordings.

I, __________________________ Name (Print) have read and consent to the above statement(s).

Signed this __________ Day of ____________________________ 20_________

WITNESS TO SIGNATURE

SIGNATURE OF PATIENT OR INDIVIDUAL
EMPOWERED TO GIVE CONSENT

PRINTED NAME OF VOLUNTEER PATIENT

Consent for Video and sound recordings on behalf of the Patient.

As the parent, spouse, next of kin, legal guardian, or a person authorized to represent the patient, I agree to the above conditions, and authorize the Health Sciences Centre and/or University of Manitoba to take video or sound recordings.

I provide this consent in the capacity of: □ Parent □ Social Worker □ Guardian □ Other ________

Name of Agency

__________________________________________

Signed this __________________________ day of ____________________________-20_________

WITNESS TO SIGNATURE

SIGNATURE OF PATIENT OR INDIVIDUAL
EMPOWERED TO GIVE CONSENT