UNIVERSITY OF MANITOBA

CONSENT FOR CLINICAL VIDEO AND AUDIO RECORDINGS

Health Sciences Centre

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

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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**