CVH-612 **CONNECTICUT VALLEY HOSPITAL**
Rev 6/08 **CONSENT TO EXHIBIT ARTWORK**
CONSENT TO PHOTOGRAPH/VIDEOTAPING

Patient Name: _____

MPI Number: _____
Print or Addressograph Imprint

Artwork Exhibit

Permission for Connecticut Valley Hospital to Exhibit my Artwork.

Location: CVH Campus or Artwork Events approved by CVH/DMHAS

Date(s): Artwork Exhibits as scheduled or Artwork Displays in various locations throughout the Campus (*example: Page Hall Treatment Center)*

☐ **No – I do not give CVH permission to exhibit my artwork.**

☐ **Yes - I hereby give permission for Connecticut Valley Hospital to exhibit my artwork.**
Sign below

Name to be displayed with the artwork:
A label identifying the artwork, materials with
☐ my full name.
☐ my initials only.
☐ Displayed as identified on the artwork (*if artist has signed/initialed the artwork*).

OR

☐ I want my artwork exhibited but I do *NOT want my name to be displayed* with the artwork.

Photograph Videotaping

Events:
CVH Campus/Unit Events (*examples: Holiday Celebrations, Patient Picnic, Dances, etc.*)
Approved Off-Ground Activities/Events (*example: NAMI Walk*)

Purposes:
Patient Use: Documentary of Patient Events, Educational/Recovery Opportunities and Feed-Back Video for Treatment Purposes
Hospital Staff Use: Education/Training

☐ **No - I do not authorize CVH to photograph or videotape me.**

☐ **Yes - I hereby authorize Connecticut Valley Hospital to photograph/videotape me under the above described events.**
Sign below

I understand that these photographs and/or videotape recordings may be:

- viewed by other patients and staff,
- posted on the units as a photo documentary in memorial of the above described events,
- used for Education/Training/Recovery Opportunities, however,
- will not be released outside of CVH or used for any other purpose without written authorization of the patient(s) in the photograph/video tape recording.

Event or condition upon which this authorization expires or date: _____
(*If blank, authorization will expire 12 months from date of signature below*.)

Signature of Patient (*or Legal Representative*): _____ Date: _____

_____ _____ Date: _____
Witness Signature Witness Printed Name

CANCELLATION/REVOCATION: _____ _____
Patient/Legal Representative Signature Date

File in Legal/Fiscal Section of the Medical Record