Consent/Authorization to Broadcast/Record with "G9MD Virtual Technology"

I, ____ (print name) the undersigned, hereby authorize and give consent for__________________________ (physician name) to video my surgery for use by Baylor Scott & White Health, its affiliates, assigns, contractors and employees (collectively, "BSWH") for the purposes of education through a web based educational program (G9MD). The G9MD Virtual Technology is a platform that allows transmission of live audio and video in a secure fashion over the internet and is primarily used for broadcasting to specifically designated physician groups or medical conferences around the world for the purpose of medical education. A copy of the live broadcast will be digitally recorded and maintained by BSWH for future medical education.

I hereby relinquish any right, title, or interest in such digital recordings, and to any control over their use for education, and to any proceeds that may arise therefrom. I hereby release and forever discharge and agree to hold harmless BSWH from any and all liability arising from the digital recordings.

I acknowledge that this consent/authorization is not a commitment by BSWH to use my Protected Health Information (PHI) for purposes of publicity, advertising, marketing, promotion, education or publication in any manner or media and that BSWH reserves the right not to use my PHI.

I understand that I have the right to revoke this consent/authorization at any time. To revoke your consent/authorization, send written notice to the Department of Perioperative Services at Baylor University Medical Center at Dallas, 3500 Gaston Avenue, Dallas, TX 75246. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation. Upon receipt of your revocation, BSWH will cease from further use of your digital video procedure for medical education purposes.

I have the right to refuse to sign this consent/authorization. Your healthcare, the payment for your healthcare, and your healthcare benefits will not be affected if you do not sign this form. You have a right to receive a copy of this form after you sign it.

I understand that once my PHI is used and/or disclosed pursuant to this consent/authorization, it may be subject to re-disclosure by the recipient(s) and no longer protected by applicable laws.

This consent/authorization expires in **1 year** from the date on this form (including after death). I understand that expiration of this consent/authorization will not cause the aforesaid audio recording, digital video, or other materials already made available as a result of this consent/authorization to be withdrawn from public circulation at the time of expiration, or any time thereafter.

Person Videotaped____ Date of Birth___________________

Address_______________________________________ City____________________ State_______ ZIP___________

CELL Phone____________________ HOME Phone____________________ OFFICE Phone ___________________

Email Address ____

Signature____ Date__________________________
Signature of person being videotaped or legally authorized representative

Legally Authorized Representative's relationship to patient ____

Witness Signature ____ Date__________________________

Witness Dept./Phone No. ____