Permission to Photograph And/Or Record Audio and Video

I, _____, hereby authorize Clifton Center for Sleep
Patient/Authorized Representative
Disorders, or their representative, to take photograph(s) and or record audio and video of
_____ to be used for medical interpretation of my sleep problem.
Name of Patient

I understand that such photograph(s), audio recording(s) and/or video recordings may be used for clinical or educational purposes or in the event of legal action. The sleep center and employees of CCSD and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s), and/or video recordings. No use of the material for education purposes will identify me by name.

I understand that I may cancel my permission to be photographed, and/or have an audio and video record (s) at any time with written authorization provided to CCSD.

_____ _____
Signature (Patient/Authorized Representative) Date

_____ _____
Relationship of Legally Authorized Representative Date