MEDIA CONSENT FORM

I, the undersigned, give St. Joseph's University Medical Center/St. Joseph's Wayne Medical Center permission to interview and/or photograph, videotape, or audio record

____
Name

and also give personnel authorized by St. Joseph's University Medical Center/St. Joseph's Wayne Medical Center permission to use, show, and/or publish such photographs, videotapes, audio recordings, and the information obtained in medical or scientific journals, books or other medical/scientific oriented media, and for public viewing on cable, public or broadcast television. I authorize the use of my name and such information which may identify me to the public and consent to an investigative background check, should my picture or video be used to represent St. Joseph's Health.

I hereby release the attending physician, the hospital, health personnel, officers, employees and agents from any and all liability which may result from the taking, printing, retaining and using of said photographs, videotapes, audio recordings, and information.

I understand further that this release shall be binding upon the person named above and upon his or her heirs, executors, administrators, successors, and assigns.

____
Witness

____
Signature

____
Date

____
Address

____
Signature of Other Person Responsible

____
Relationship

If a patient is a minor, indicate age ___________

PLEASE RETURN THE COMPLETED FORM TO THE PUBLIC RELATIONS/MARKETING DEPARTMENT.
TELEPHONE #: 973.754.4500 FAX #: 973.569-6039