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

Patient Name: ____________________  MPI Number: ____________________

Print or Addressograph Imprint

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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.

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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.

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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: ____________________

Witness Signature  Witness Printed Name

Date: ____________________  Date: ____________________

CANCELATION/REVOCATION:

Patient/Legal Representative Signature  Date

File in Legal/Fiscal Section of the Medical Record