I, _____, the undersigned, hereby grant permission to Altru Health System to do the following:

☐ Release information to the media for a feature story

☐ Video record and/or photograph self for promotional purposes

☐ Other _____

My signature also means that I have read this form and/or have had it read to me and explained in a language that I can understand.

I understand that I may revoke this consent at any time by notifying Altru Health System in writing except to the extent that action has already been taken.

Date _____

Signed _____
(Patient or closest relative or legal guardian)

Date of Birth _____

Witness _____

Relationship (must check one)

☐ Self

☐ Mother/Father

☐ Daughter/Son

☐ Spouse/Partner

☐ Other: _____