Authorization to Photograph, Videotape, or Film
Participant in Mayo Clinic Event

I consent to ____________________________being photographed, videotaped or filmed
Participant Name
by Mayo Clinic while I am participating in Mayo Clinic sponsored events or activities.

I consent to Mayo Clinic using the photographs, videotapes or films (collectively, the "Materials") for Mayo Clinic's internal health care operations, such as to improve quality of care to patients and to educate students and professionals at facilities staffed by Mayo Clinic. I also consent to Mayo clinic using and disclosing the Materials for external scientific, educational, and media-related purposes.

I agree that Materials shall be the sole exclusive property of Mayo Clinic, free and clear of any claim on my part, and that I shall receive no royalties or other compensation or consideration for the Materials.

I release Mayo Clinic and its personnel from any and all liabilities which may arise from the use or disclosure of Materials and information under this authorization.

As a participant in Mayo Clinic sponsored events, I may observe unique techniques, modalities, approaches, procedures or training activities that constitute confidential proprietary information belonging to Mayo Clinic. I agree not to disclose to third parties and to maintain the confidentiality of such information.

I understand that I may revoke this authorization at any time except to the extent that Mayo Clinic has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the Mayo School of Health Sciences. I understand that this authorization will remain in effect unless specifically revoked by me.

____
Printed Name of Participant *or* parent/legal guardian if Participant is a minor

____
Signature

____
Date