Lifespan
Physician Group, Inc.

[redacted]
Phone: [redacted]

PATIENT CONSENT FORM – FOR USE WHEN SEEKING PATIENT CONSENT TO RECORD IMAGES OF PATIENTS FOR USE IN EDUCATION OR PERFORMANCE IMPROVEMENT PRODUCTIONS.

[redacted] [redacted]
Name of Patient Date

I agree and consent to the taking, gathering or in some other fashion, recording images in any medium or format (all of which are referred to in this Consent as "Recorded Images") to be used for the purpose of education of or performance improvement related to patients, physicians or Hospital staff.

I understand my name and identity will not be revealed, unless specifically explained to me below and/or in an attached writing.

I understand that I may refuse to give you my consent (and signature) and that my refusal will not in any way affect the treatment or care plan designed and delivered by my care team.

Description of Recorded Images to be taken and planned use (may attach additional pages):

[redacted]

Length of time Recorded Images will likely be used:

[redacted]

I understand that I may withdraw this consent and request that the recordings stop at any time.

Please consent to or deny use of Recorded Images in the followings situations:

- Examination, testing, credentialing, and/or certifying purposes by any medical record — Yes No
- Performance improvement purposes — Yes No
- Education of clinicians or hospital staff — Yes No
- Education at seminars, health fairs and conferences — Yes No
- In articles written for publication in Medical Journals — Yes No

I have read and understand this Consent Form, or it has been explained to me, and questions about it have been answered to my satisfaction. I am signing this consent entirely of my free will. I understand this Consent is valid for the recordings described above made during this present stay or visit to the hospital. My additional consent will be sought for any additional recordings requested. I hereby release Rhode Island Hospital, Lifespan Physician Group, Inc. and Lifespan Corporation from any liability related to the recording and/or use of these images.

[redacted] [redacted]
Print /Signature of Patient (or legal Representative) Date/Time

Print Name of Legal Representative (if Applicable) Relationship to Patient

I certify that I have explained the nature and proposed use of the recorded images to the patient and/or their legal representative. I have provided a description of said use above. I believe that the patient/legal guardian fully. I understand what I have explained.

[redacted] [redacted]
Hospital Staff Signature/Print Name Date/Time