

I hereby consent to the video and audio recording/broadcasting by my support person, _____, of my labor and delivery. This may include my labor, vaginal or cesarean delivery, or the care of my infant. I have discussed this with my obstetrician and nurses and they agree to the recording/broadcasting. I acknowledge that my support person is recording/broadcasting my labor, delivery, and/or infant care solely at my request and with my full permission. This video and audio recording/broadcasting is being done through one of the following means: camcorder, digital camera, cell phone or other digital video recording/broadcasting equipment.

I understand and agree that only a hand-held recording/broadcasting device may be used by my support person and that the positioning of the device and of my support person will be directed by my physician or nurses.

I further understand and agree that any Medical Staff member or any employee or agent of Pinnacle Health Hospitals may refuse to have their likeness or voice recorded/broadcast in which case I understand and agree not to record/broadcast or have recorded/broadcast that person's likeness or voice.

I understand and agree that Pinnacle Health Hospitals is not responsible for any of the equipment used to record/broadcast my labor and delivery and is not responsible to any third party who views, listens to, or otherwise comes into contact with the recording/broadcast.

I further understand that my support person will be recording/broadcasting a medical procedure and hereby release Pinnacle Health and its agents, employees and Medical Staff members from any and all injuries, losses, or damages of any kind which arise as a result of my support person recording/broadcasting my labor and delivery.

 Witness Patient Date Time

I have read and agree to be fully bound by the terms and conditions of the above consent. I hereby release Pinnacle Health Hospitals and its agents, employees, and Medical Staff members from any and all injuries, losses or damages of any kind which arise as a result of my recording/broadcasting of the above-referenced patient's labor and delivery. I acknowledge that I am recording/broadcasting the patient's labor and delivery solely at the request and with the full permission of the patient.

 Witness Support Person Date Time

 Physician Date Time

No, I do not want my labor and/or delivery or the care of my infant video or audio recorded/broadcast.

 Witness Patient Date Time



PINNACLE HEALTH
Hospitals

**CONSENT TO RECORD/BROADCAST
LABOR AND DELIVERY**



CO2201

Patient Identification