MetroHealth Simulation Center
Authorization Release for Photography and Video
&
Confidentiality Agreement

I, _____, understand that the MetroHealth Simulation Center (MHSC) may photograph and/or record (via still photos, video and/or audio) the simulation experience.

I understand with my signature below, I will forfeit all rights of this material, and will not receive any payment or special services now or in the future.

I understand that any photo or audio/video recordings may be used during the debriefing of a scenario and/or following the program for internal review and quality improvement by MHSC staff, faculty and instructors. I further understand that no recording will be used for promotional or marketing purposes without additional permission.

I agree to maintain and hold confidential all information regarding the performance of all individuals and the details of the programs and scenarios, which are the intellectual property of MHSC.

I understand that I may revoke my authorization at any time by providing a written request to:

Jackelyn Csank
Manager, MetroHealth Simulation Center
MetroHealth Simulation Center
2500 MetroHealth Dr.
Cleveland, Ohio 44109

_____ _____
Participant Signature Date MHSC Staff Signature Date

_____ _____
Name Printed Emp ID #