

WLS Patient Testimonial

Name: _____

Today's Date: _____ **Date of Surgery:** _____

Consider including a discussion of the following:

General health issues and quality of life before surgery
Prior attempts at weight loss before surgery
Experience with the Duke WLS Program personnel
Issues with Insurance if any
Operative experience
Hospital experience
Changes in health issues and quality of life after surgery
Would you do it again?

Return this form and the following signed consent to:

Duke Weight Loss Surgery Program
3116 N. Duke Street
Suite 209
Durham, NC 27704



AUTHORIZATION FOR RELEASE OF INFORMATION AND/OR PHOTO

If you choose to be photographed, videotaped or audiotaped or have protected health information concerning you or your dependent released to the media, please complete the appropriate paragraph(s) below:

RELEASE OF PROTECTED HEALTH INFORMATION AND/OR CONSENT TO MEDIA

I, [Name] authorize Duke University, Duke University Health System, the Private Diagnostic Clinic and other members of the Duke Health Enterprise (Duke) identified in the Notice of Privacy Practice to release the following: The text and pictures in the attached "Testimonial" about my WLS experience

about me or my dependent [Name] to the news media for the following purpose: For inclusion in the DukeHealth.org Web site

Expiration date or an expiration event: 100 Years from today's date

PERMISSION FOR PHOTOGRAPHS/VIDEO TAPING

I, [Name] authorize Duke to permit its representatives and/or the news media to take photographs or video tape of me or my dependent [Name], while I (he/she) am (is) a patient. I understand that Duke retains no control of the use of any photograph or videotape that is released to or taken by the news media.

Expiration date or an expiration event: 100 Years from today's date

PERMISSION FOR AUDIO TAPING

I, [Name] authorize Duke to permit the news media to record audio tape of me or my dependent, [Name], while I (he/she) am (is) a patient. I understand that Duke retains no control of the use of any audio recording that is released to or made by the news media.

Expiration date or an expiration event: 100 Years from today's date

PERMISSION FOR RELEASE OF INFORMATION FOR MARKETING/ADVERTISING PURPOSES

I, [Name] authorize Duke to take photographs of me or my dependent, [Name], while I (he/she) am (is) a patient for use in marketing or advertising its services. I understand that the photographs, video tape or audio tape will be used primarily for marketing or advertising purposes, such as brochures, newsletter, Duke Web site and advertising.

Expiration date or an expiration event: 100 Years from today's date

PERMISSION FOR PHOTOGRAPHY/VIDEOGRAPHY FOR MEDICAL EDUCATION/MEDICAL ILLUSTRATION

I, [Name] authorize Duke to photograph or video tape me or my dependent, [Name], while I (he/she) am (is) a patient. I understand the photographs or videotape may be used in any manner considered proper by the Duke administration but will be used primarily for informational purposes, medical education or medical illustration.

Expiration date or an expiration event: 100 Years from today's date

I understand that:

If the materials are copyrighted by Duke, the material will be under the control of Duke. I understand, however, that once information and/or materials are released to the public information media - including but not limited to television, newspaper, magazine, radio, and the internet - Duke no longer has control over their use.

I hereby release and discharge Duke as well as their assigns and/or representatives from any and all claims and demands arising out of or in connection with the use of the photographs, video tape, audio tape and/or release of protected health information.

I will receive no compensation for consent for the release of this material. I also understand that participating in this project will not in any way affect the care I (he/she) receive(s) or our medical bills through Duke.

I have read this form and fully understand the contents. I agree to be bound by this consent form. I acknowledge and represent that I am 18 years of age or older and have the right to contract in my own name or that I am legally authorized to sign this form for the patient.

I have the right not to be photographed, video taped or audio taped or have protected health information concerning me or my dependent released to the media. Choosing not to participate will in no way compromise the care I receive.

This authorization may be revoked at any time. Revocation must be made in writing and sent to the Durham Regional Marketing Department, 3643 N. Roxboro Road, Durham, NC 27704 or faxed to 919-470-8545. Such revocation shall not affect disclosures prior to revocation. I understand that Duke retains no control over the use of this information once it is released to the media.

WITNESS

DATE



SIGNATURE

RELATIONSHIP