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- Name
- Image, Photograph
- Voice
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By signing below, I certify that I have read, understood and agree to the contents of this document.

**Participant Signature:**
(where participant is at least 19 years of age)

____________________________________________________

**Print Name:**

____________________________________________________

**Date:**

____________________________________________________

**Telephone:**

____________________________________________________

**Parent/legal guardian:**
(where participant is less than 19 years of age)

____________________________________________________

**Print Name:**

____________________________________________________

**Date:**

____________________________________________________

**Telephone:**

____________________________________________________

The Organizations collect, use and disclose personal information in accordance with, where applicable, the *Freedom of Information and Protection of Privacy Act* (British Columbia) and/or the *Personal Information Protection Act* (British Columbia). If you have any questions about the collection, use or disclosure of this information by the Organizations please contact the Information Privacy Office at Vancouver Coastal Health Authority at 604.875.5568 or VGH & UBC Hospital Foundation at 604.875.4676.

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**SUBJECT OF IMAGE**

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**PHOTOGRAPHER - NAME**

____________________________________________________

**ADDRESS**

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**LOCATION OF SHOOT**

____________________________________________________

**SUBJECT/PROJECT** – (e.g. name of machine, department being represented, etc., please identify subject for group shots i.e. red top, left, middle, front row L-R, etc.)

____________________________________________________