



# Assistive Technology Partners

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## Video/Photo Consent

I (name) \_\_\_\_\_ voluntarily give my permission to the University of Colorado at Denver and Health Sciences Center to photograph or videotape myself or (name) \_\_\_\_\_ .

I understand that all right, title, and interest in these photographic images belong exclusively to the University of Colorado at Denver and Health Sciences Center and that the University reserves the right to edit the images, and in the event consideration is paid or received for use of said images, I shall in no way be entitled to such consideration.

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I further acknowledge that I am fully cognizant of the contents hereof and am under no duress or undue influence at the time of my execution of this instrument.

I give my permission for these photos/clips taken today to be edited and used by Assistive Technology Partners, at the University of Colorado at Denver and Health Sciences Center for:

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This authorization will expire on the following: 365 days from date signed

Participant: \_\_\_\_\_ Date: \_\_\_\_\_

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\_\_\_\_\_ YES, it is acceptable to disclose my identity. \_\_\_\_\_ NO, I do not want my identity disclosed.

Description of Picture: \_\_\_\_\_

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