UC Riverside, School of Medicine Policies and Procedures
Policy Title: **Photography Multi-Media Privacy and Security Recording of Patients**
Policy Number: 950-02-006

Responsible Officer:	Chief Compliance and Privacy Officer
Responsible Office:	Compliance Office
Origination Date:	07/2013
Date of Revision:	1/2016, 3/2016, 12/2019, 7/2021
Scope:	UCR School of Medicine and all UCR Faculty Practice Sites

I. Policy Summary:

The purpose of this policy is to specify the conditions and requirements for the recording of audio, video, or still images (photography) of people in the UCR School of Medicine and UCR Health facilities. This includes all recordings for commercial, marketing, promotional, historical, treatment, social media, educational or research purposes conducted by UCR, the School of Medicine, and UCR Health, as well as recordings done by external parties for news coverage or commercial purposes.

II. Definitions:

Refer to Standard Definition Guide Document.

III. Policy:

A. It is the policy that no recording of audio, video, or still images of patients, staff, faculty, residents, fellows, other employees, students, or other guests of UCR School of Medicine or UCR Health is allowed unless it meets the requirements set forth in this Policy, which is intended to protect the confidentiality and privacy of participants while allowing the activity under appropriate circumstances.

1. No activity that interferes with patient care, functions, education or training will be allowed.
2. All subjects participating in the activity must sign the appropriate permission forms, with these forms sent to and maintained by the UCR SOM Compliance Office.
3. Agreements to participate do not expire, with the exception of patients who have the right to revoke their consent at any time, including after the recordings have been distributed. This is with the caveat that items released publicly may not be capable of being recalled.
4. Photos or other recordings taken for patient-care purposes should placed in the patient's legal health care record and deleted from the camera in accordance with the University's Terms and Conditions provisions relating to Medical Photography.
5. All other recordings will be stored digitally by UCR, the UCR School of Medicine, and UCR Health, with access provided only to those individuals who require it.
6. Patient use of any electronic recording device is prohibited without the express consent of the faculty and staff. This includes all social media platforms

IV. Procedures:

A. All Staff And Registration Staff

1. All individuals participating in the recording of audio, video, or photography, should sign the appropriate release form in advance of the recording. The forms should be recorded and saved by the Compliance Office.
2. Individuals participating in events that do not involve protected health information (PHI), including individuals participating in staged events, should sign the form in **Appendix A**.
3. All Medical and Biomedical Sciences students sign **Appendix A** form during their first year onboarding granting their consent to be recorded. This form follows them throughout their medical education career. Students who wish to opt-out of this form for any reason should contact the Registrar in the Office of Student Affairs and the SOM will work with the student to exclude their images whenever possible.
4. In the case of recordings made at School of Medicine and UCR Health events where no protected health information will be shared and where it would be unreasonable to get individual permission forms all participants, event organizers should make a general statement, either in writing prior to the event or by using signage or verbally during the event, about recording taking place and inform individuals how they can opt out from participation.
5. Individuals, including patients, involved in events that may include the recording of protected health information (PHI), should use **Appendix B** to provide written consent. The forms should be signed by the patient, or their parent or guardian if they are under the age of 18.
6. Medical Photography is covered in the University's Terms and Conditions form given to all patients at first encounter in the ambulatory practices, and a separate consent form is not required.
7. Any photography, video and or audio recordings involving patients that may include PHI, regardless of purpose, must also use **Appendix C** and specify the purpose for the recording.
8. Patients must be told that they have the right to revoke consent for use of the content at any time, except to the extent that the UCR SOM, UCR Health or others have relied on it. The revocation applies immediately upon receipt by UCR. It is understood the revocation only addresses further distribution of the content and that items that have been released to the public may not be able to be recalled or removed.
9. All individuals involved in the recording of a patient is subject to the confidentiality policies of the UCR School of Medicine and UCR Health and are bound to protect the patient's identity and any confidential information. These individuals should use **Appendix E** "Confidentiality Statement for Non-Workforce Members."
10. Written consent from the patient is required in advance of the photography, except in the limited circumstances if photography is performed by UCR School of Medicine or UCR Health faculty for research or teaching purposes, and it is not possible to obtain consent in advance.
    a. The patient or the patient's personal representative shall be informed of recording that occurred prior to obtaining the signed Terms and Conditions form.
    b. In these limited circumstances when consent cannot be obtained in advance, the film or other media used for the photography, must remain in the possession of the UCR School of Medicine or UCR Health and not used for any purpose, until appropriate consent has been obtained.
    c. If the consent is not obtained, then the images must be destroyed.
11. Photography for research purposes must be included in the IRB approval for the

protocol, and appropriate patient consent obtained as permitted by the IRB. The applicable HIPAA Research Authorization must also cover the use and disclosure of photograph(s). The photographs must stay with the protocol binder or medical record if for clinical care. Any additional uses of the materials may require additional authorization from the research subject.

12. Research Subject Consent may not be required if the photography is used for research or teaching purposes and the patient is not identifiable. Photographs and images collected prospectively for a research project may require a waiver of authorization or consent from the IRB to collect and use the images. Research protocols requiring photography with patient identifiers as part of the study would have a patient consent and HIPAA Research Authorization for the use of PHI. However, the IRB approval for the protocol must still include the photography in the approved protocol.
13. If the protocol requires the de-identification of the photographic images, the images must be de-identified by:
    a. Masking of identifiable features so that the image is not recognizable; or
    b. Removal of all labels containing patient name, medical record number, date of service, account number and any other unique identifiers. Refer to **Appendix D** which lists the 18 identifiers that must be removed in order to de-identify patient information.
14. Photography is prohibited if, in the opinion of the patient's attending physician, the photography will jeopardize the patient's condition or interfere with the care of the patient, or if the patient requests that the filming stop. The patient has the right at any time to request that the filming stop.
15. Photography by outside organizations requires oversight by the UCR School of Medicine Compliance and Privacy Office and School of Medicine Strategic Initiatives Office. Anyone who photographs or videotapes for commercial purposes who is not a UCR Health employee and not a member of the news media must sign an appropriate Confidentiality Statement for Non-Workforce Members (Appendix E) to protect the patient's identity and confidential information and abide by relevant UCR campus policies for commercial filming.
16. Reporters and News crews must wear proper media credentials and should be accompanied by a member of the UCR SOM Office of Strategic Initiatives, UCR University Communications, or the appropriate designee
17. Such Photography must comply with UCR Health's Policy on Access, Use and Disclosure of PHI. Appropriate notice must be given if filming occurs in UCR Health facilities, such as posting signs in public areas. News crews must wear proper media credentials
18. If the Photography includes third parties (other than the patient) such as staff, visitors, students or trainees, their written or verbal consent must be obtained, except in public areas. If such consent is not possible, the Compliance and Privacy Director should be contacted. If it is determined that consent was not obtained, then UCR Health may retain the film, negatives, or other electronic media used for the Photography.
    When Photographs are utilized for demonstration of 'before and after' results, the Consent to Photograph and Authorization for Use and Disclosure (Appendix E) must be completed and signed by the patient. The specifics of the areas photographed and a clear statement of how the photographs will be utilized must be included in this authorization.

B. Medical Records

1. Patient photographs are subject to the laws governing confidentiality of medical information. Original Authorization and Consent Form(s) signed by the patient authorizing the photography should be placed in the patient's medical record. A copy of the Consent Form should be maintained by the Department requesting the Photographs and a copy should be given to the patient.
2. For Medical Photography or abuse reporting, the photographs including any negatives should be maintained in the Medical Record.
3. UCR Health workforce members may not post, distribute, send or otherwise disclose pictures of patients through email, internet postings or text or picture messaging via cell phones or other public forum. Violations will subject workforce members to discipline up to and including termination.

C. All Staff

1. All photographs taken in any format must be secured according to the UCR Health policy *Use of Protected Health Information on Portable Computing Devices*.
2. For medical photographs taken on digital cameras, the electronic image on the camera must be deleted after the photograph is incorporated into the patient medical record.
3. For photographs taken for educational and research purposes, the information and images can only be used or disclosed as authorized by the patient in the applicable authorization and/or consent form and as per the IRB protocol approval. The Attending Physician and/or Principal Investigator are responsible for storage and safeguarding of the patient's photographic information until no longer needed or until the patient's authorization expires.

D. Abuse and Reporting Requirements

1. Physicians, Nurses
   a. If the photographs will be used for purposes of diagnosing or reporting possible abuse, including child abuse, consent is not required.
2. Physician Risk Management
   a. If the patient's ability to give consent is impaired, and if the physician or law enforcement officer determines that photographs are necessary to preserve evidence of the patient's physical condition, the physician may authorize the photographs. The Compliance and Privacy Director should be contacted as appropriate in these situations for further guidance.
   b. The physician should document this determination in a dated and timed note in the patient's medical record. If a law enforcement officer requested the photographs, the officer's name and badge number shall be documented in the medical record.

VI. Forms/Attachments:

Appendix A: Marketing and Promotional Photo, Video, & Audio Release (Non-PHI)
Appendix B: Consent for Photography, Video, & Audio Release for Educational Purposes (PHI)
Appendix C: Authorization to Use and Disclose Protected Health Information for Media/Marketing and Other Related Purposes

Appendix D: Identifiers to be Removed to De-Identify Patient Information
Appendix E: Confidentiality Statement for Non-Workforce Members
Appendix F: Consent for Before-and-After Photograph and Authorization for Use and Disclosure

VII. Related Information: N/A

VIII. Revision History: 1/2016 , 3/2016, 12/2019, 7/2021

Approvals:

Paul Hackman Digitally signed by Paul Hackman Date: 2021.08.05 15:54:07 -07'00'

08/05/21

PAUL HACKMAN, J.D., L.LM.
CHIEF COMPLIANCE AND PRIVACY OFFICER,
SCHOOL OF MEDICINE

DATE

Deborah Deas, MD, MPH Digitally signed by Deborah Deas, MD, MPH Date: 2021.08.12 14:18:11 -07'00'

DEBORAH DEAS, M.D., M.P.H
VICE CHANCELLOR, HEALTH SCIENCES
DEAN, SCHOOL OF MEDICINE

DATE

Appendix A
Marketing and Promotional Photo, Video, & Audio Release (Non-PHI)

UC RIVERSIDE School of Medicine

Your Information		
Name		
Address		
City	**State**	**Zip**
Phone:	**Email:**	
Type: ☐ Faculty ☐ Medical Student ☐ Grad Student ☐ Medical Student ☐ Staff ☐ Other_____		
☐ I am at least 18 years old.	☐ I am signing as the parent/guardian of:	

Project Information				
Name:				
Type:	☐ Photo	☐ Videos	☐ Audio	☐ Other:

Purpose: By signing this document, you voluntarily grant UCR, the UCR School of Medicine, and/or UCR Health permission to take and use photographs, record audio and/or video, or other multimedia in any-and-all promotional materials and publicity efforts. I understand that all content may be used in print, digital or other forms, in accordance with SOM policy 950-02-006.
I release the university, the photographer/videographer, their officers, employees, agents, and designees from liability for any violation of any personal or proprietary right I may have in connection with such use. I agree that UCR, the UCR School of Medicine and/or UCR Health own all rights to the multimedia items listed above. I waive all rights that I may have in the use of my likeness. The organizations will have the right to reproduce, distribute, sell, transmit, publish, exhibit, or otherwise use all the content listed above. I will not receive any payment for any subsequent use of them.
Unless otherwise indicated, this authorization does not expire. If a request to revoke permission is received, it is understood that items that have been released into public may not be able to be recalled or removed.

Signature of Individual, Patient, or Legal Representative	**Date**	**Relationship to Patient**
Signature of Witness or Interpreter	**Date**	**Phone number**
Signature of Person Obtaining Consent	**Date**	

Appendix B
Consent for Photography, Video, and Audio Release for Educational Purposes (PHI)

UC RIVERSIDE School of Medicine

Your Information		
Name		
Address		
City	**State**	**Zip**
Phone:	**Email:**	
☐ I am at least 18 years old.	☐ I am signing as the parent/guardian of:	

Patient Information	
Name: (If different from above)	**UCR Health** **Medical Record #:**
Physician Name:	**Department:**
Date(s) of treatment:	**Types of Health Info:**

Project Information
Name:
Type: ☐ Photo ☐ Videos ☐ Audio ☐ Promotional ☐ Educational ☐ Other _____
Purpose:

Purpose: By signing this document, you voluntarily grant UCR, the UCR School of Medicine, and/or UCR Health permission to take photographs, record audio and/or video, or other multimedia content that may contain health information about you during your healthcare treatment at the UCR Health ambulatory practice, UCR SOM sponsored clinic, or similar event, in accordance with SOM policy 950-02-006.
Your rights: You have the right to stop recording or photography at any time and may refuse to give permission without any penalty or loss of care or services. Your treatment, payment, enrollment, and eligibility for benefits do not depend on your granting permission.

- You will not be identified by name, but your face, voice, or other information that is unique to you may be recognized by others.
- The multimedia items will be stored on UCR SOM computers without your name. This form will be stored by the UCR School of Medicine.
- If you have any questions about your rights, please contact UCR Health Compliance via email at compliance@medsch.ucr.edu.

Expiration: Unless otherwise indicated, this authorization does not expire. If a request to revoke permission is received, it is understood that items that have been released into public may not be able to be recalled or removed **Initial** _____
I agree that UCR, the UCR School of Medicine and/or UCR Health own all rights to the multimedia items listed above. I waive all rights that I may have in the use of my likeness. The organizations will have the right to reproduce, distribute, sell, transmit, publish, exhibit, or otherwise use all the content listed above. I will not receive any payment for any use of them.
I have read this consent about the use of multimedia items that contain my health information. I understand the permissions I am giving. My questions have been answered to my satisfaction and I agree to what this form says. I will receive a copy of this form if requested.

Signature of Patient or Legal Representative	**Date**	**Relationship to Patient**
Signature of Witness or Interpreter	**Date**	**Phone number**
Signature of Person Obtaining Consent	**Date**	

Appendix C

Authorization to Use and Disclose Protected Health Information (PHI) for Media/Marketing and Other Related Purposes

1. UCR Health may use my protected health information for the following purposes
   - ☐ Marketing (e.g. brochures, billboards, other advertisements, about UCR, UCRSOM or UCR Health)
   - ☐ Print or electronic media (e.g. television, newspapers, magazines, both print and electronic)
   - ☐ Videography
   - ☐ Media or entertainment consultants
   - ☐ Other (specify)
   - ☐ I authorize UCR, the UCR School of Medicine, and/or UCR Health to release my protected health information (PHI) to the following organizations (if applicable)

2. Types of PHI that may be used or disclosed

☐ All of the following	☐ Email address	☐ Diagnosis/Method of Treatment
☐ Name	☐ Date of Birth and/or Age	
☐ Address, City and State	☐ Photograph/Video Image	☐ Date(s) of Treatment
☐ Phone number	☐ Personal Story	☐ Other (specify)

3. Once my health information is disclosed to the public, including members of the news media, UCR cannot guarantee that the information will not be re-disclosed to others.
4. Recipients of my PHI may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my PHI.
5. I may refuse to sign or may revoke (at any time) this authorization for any reason and that refusal or revocation will not affect the commencement, continuation, or quality of my treatment at UCR Health.
6. This authorization does not expire unless a specific expiration date is set.
   Expiration Date:_____
7. I may, at any time, provide written notice of revocation to UCR, UCR SOM, or UCR Health. The revocation will be effective immediately upon receipt of my written notice. At that point, there will be no further distribution of the content. I understand that it may not be possible to recall or remove items that have been published or otherwise released to the public. **Initial** _____
8. The revocation will not have any effect on any action taken by UCR Health in reliance on this authorization before it received my written notice of revocation.
9. Questions regarding this authorization, the use of my PHI, or my desire to revoke this authorization should be addressed to UCR SOM Compliance and Privacy Office, 900 University Ave., Riverside, CA, 92521 or via email at compliance@medsch.ucr.edu.

Signature of Patient or Legal Representative	**Print Name**	**Date**

Patient name	**Date of birth**	**Your relationship to patient**

Home Address, City, State, Zip	**Phone**

Appendix D
Identifiers to be Removed to De-Identify Patient Information

The following 18 identifiers must be removed in order to de-identify patient information, as stated in policy 950-02-006.

1. Names
2. Street Address, City, State, Zip code *
3. All dates (including dates of treatment):
   - Age <90: All elements of dates, except year;
   - Age >89: All elements of dates including year
4. Telephone numbers
5. Fax numbers
6. Electronic mail addresses
7. Social Security numbers
8. Medical record numbers
9. Health plan beneficiary numbers
10. Account numbers
11. Certificate license numbers
12. Vehicle identifiers and license numbers
13. Device identifiers and serial numbers
14. Web universal resource locator (URL)
15. Internet protocol (IP) address number
16. Biometric identifiers, including finger or voice prints
17. Full face photographic images and any comparable images
18. Any other unique identifying number, characteristic, or code

Appendix E

Confidentiality Statement for Non-Workforce Members

(2 pages)

UC RIVERSIDE School of Medicine

Your Information	
Name:	**Title:**
Organization:	
Purpose/ Project:	

The federal Health Insurance Portability and Accountability Act ("HIPAA") and its regulations, the California Confidentiality of Medical Information Act and other federal and state laws and regulations were established to protect the confidentiality of medical and personal information, and provide, generally, that patient information may not be disclosed except as permitted or required by law or unless authorized by the patient.

In certain circumstances, HIPAA allows the disclosure of limited patient information in order to carry out treatment, education, research, public health, or health care operations activities without obtaining the patient or subject's authorization.

Please review the details of the Confidentiality Statement on the reverse of this page.

Signature

Signature **Date**

Confidentiality Statement for Non-Workforce Members

(Continued)

About Confidential Patient Information (Initial ___)
Confidential Patient Information includes: Any individually identifiable information in possession of or derived from a provider of health care regarding a patient's medical history, mental or physical condition or treatment, as well as the patients' and/or their family members' records, test results, conversations, research records and financial information.

This information is defined in the Privacy Rule as "protected health information" (PHI). Examples include but are not limited to:

- ☐ Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- ☐ Patient insurance and billing records;
- ☐ Computerized patient data;
- ☐ Visual observation of patients receive medical care or accessing services; and
- ☐ Verbal information provided by or about a patient.

I understand and agree that this document establishes a Confidentiality Agreement between me and UC Riverside and sets forth the understanding regarding the protection of any confidential information that Individual may have access to while performing services at UC Riverside.

1. I understand that I will be granted access to, or otherwise become acquainted with, the following information ("Information") relating to UC Riverside Health patients:
   - ☐ Clinical/medical information
   - ☐ Insurance and Billing information
   - ☐ Scheduling information
   - ☐ Visual observation of patients receiving medical care or accessing services
   - ☐ Other (describe)_____

   It is understood and agreed that except as required by law, I will use and hold all Information in strict trust and confidence and will use such information only for the purposes contemplated herein, and not for any other purpose.

2. I acknowledge that it is my responsibility to respect the privacy and confidentiality of Information received from UC Riverside I will not access, use or disclose patient or other confidential information unless I am authorized or permitted to do so by law or as authorized by the patient. I further understand that I am required to immediately report any information about authorized access use or disclosure of confidential patient information to UC Riverside.

3. I agree to not disclose the Information to any other individuals.

4. Neither the release of any information hereunder or the act of disclosure shall constitute a grant of any license under a trademark, patent, or copyright or application of the same.

5. I understand and acknowledge that, should I breach any provision of this Confidentiality Statement, I may be subject to civil or criminal liability.

Appendix F

Consent for Before-and-After Photographs and Authorization for Use and Disclosure

(2 pages)

UC RIVERSIDE School of Medicine

Patient Information		
Name		
Address		
City	**State**	**Zip**
Phone:	**Email:**	
☐ I am at least 18 years old.	☐ I am signing as the parent/guardian of:	

Specific Area to be Photographed/Viewed

Signatures

Signature of Patient or Legal Representative **Print Name** **Date**

Patient name **Date of birth** **Your relationship to patient**

Home Address, City, State, Zip **Phone**

If this form is verbally translated, please complete the following section

Name of translator or translation service **Translation to what language**

Signature or ID Number

Please read the reverse of this form to read about your rights

Consent for Before-and-After Photographs and Authorization for Use and Disclosure

Authorization for Use and Disclosure (Initial ___)

- I consent to be photographed, including still photography or video, in digital or any other format, or any other means of recording or reproducing images, while receiving treatment at UCR Health.
- I authorize the use or disclosure of imagery in order to assist scientific, treatment, educational and other goals.
- I waive any right to compensation for such uses by reason of the foregoing authorization.
- I and my successors or assigns hold the UCR School of Medicine and UCR Health, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.
- I authorize the use of photographs by the UCR School of Medicine and UCR Health for the purpose of demonstrating before-and- after procedure comparisons.
- I consent to my photographs being viewed by third parties including other patients and their family members, at the discretion of UCR School of Medicine faculty.

My Rights (Initial ___)

- I may request cessation of recording at any time.
- I may rescind this authorization up until a reasonable time before the image is used by submitting a written request to the UC Riverside SOM Compliance Office, 900 University Ave., Riverside, CA 92521
- I may submit a written notice of revocation after the image is used. The revocation will be effective immediately upon receipt of my written notice. At that point, there will be no further distribution of the content.
- I understand that it may not be possible to recall or remove items that have been published or otherwise released to the public.
- I may inspect or obtain a copy of the photograph whose use or disclosure I am authorizing.
- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.
- I have the right to receive a copy of this authorization
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).
- I will not receive any financial compensation.

Expiration (Initial ___)

- This authorization does not expire unless a specific expiration date is set.

  Expiration Date:_____

- I understand that the expiration date stops further distribution of the content and that it may not be possible to recall or remove items that have been published or otherwise released to the public.