

**CONSENT FOR PHOTOGRAPHY AND  
AUTHORIZATION FOR RELEASE OF MULTI-MEDIA FOR EDUCATIONAL PURPOSES**

UCR Health Medical Record #  
Patient Name:

Faculty Member/Attending Physician Name \_\_\_\_\_  
Department \_\_\_\_\_  
Telephone Number \_\_\_\_\_

**Purpose:** We ask your permission to take photographs, record films and/or create multi-media items that contain health information about you. The multimedia items will be taken or made during the course of a healthcare treatment at the UCR Health ambulatory practice. We want to share this health information about you with other individuals and entities either inside or outside UCR Health for educational purposes, so that other health sciences professionals and students can learn about your condition or disease. This will benefit other patients.

**Confidentiality:** You will not be identified by your name. Other people may recognize your face or voice or other information that is unique to you. The multimedia items will be edited and stored on a computer without your name.

**Notice:** UCR Health and many other organizations and individuals such as doctors, nurses, dentists, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

**Your Rights:** You have the right to have the filming or photography stop at any time, and have the right to revoke your consent at any time, prior to publication. Upon publication, it is not possible to rescind your consent. Giving permission for us to use these items is voluntary. You 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 signing this permission form. If you have any questions about your rights, contact the UCR Health Compliance and Privacy Office, 900 University Avenue, Riverside, California 92521.

**Expiration:** Unless you revoke your permission earlier, this authorization expires on \_\_\_\_\_. If no date is indicated, this authorization will expire fifty years after the date of your signing this form.

I give permission for these multimedia items to be taken or made and used:

- Photographs: \_\_\_\_\_
- Videos/films: \_\_\_\_\_
- Audiotapes/audioclips: \_\_\_\_\_
- Radiographs and other medical images: \_\_\_\_\_
- Other multimedia items: \_\_\_\_\_

Health information regarding my medical condition or treatment to be released (please specify the health information you authorize for release):

- Type(s) of health information: \_\_\_\_\_
- Date(s) of treatment: \_\_\_\_\_

**I give permission to UCR Health to use these multimedia items for these educational purpose(s):**

- Training of health sciences professionals at UC Riverside, including students, faculty and others in the UC Riverside School of Medicine (for example classroom lectures, faculty presentations, student projects, laboratory manuals, and online curriculum materials).
- Use in professional publications, presentations, textbooks and at professional conferences.
- Storage in repositories and databases of teaching materials for the health sciences.

**Revoking Your Permission:** You may change your mind and withdraw your permission for use of the photographs, films or other materials at any time, without any penalty or loss of care or services. To revoke your permission, write a letter, sign it and deliver it to the UCR Health, Compliance and Privacy Office, 900 University Avenue, Riverside, California 92521.

The revocation letter will take effect when UCR Health receives it, except to the extent that UCR Health or others have already relied on it. If the multimedia items have been shared, it may not be possible to recall them.

**I agree that UCR Health will own any and all rights in the multimedia items listed above. I waive any and all right that I may have in the use of my likeness or photographs. UCR Health will have the right to reproduce, distribute, sell, transmit, publish, exhibit, or otherwise use the multimedia items 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 get a copy of this consent.**

\_\_\_\_\_  
Signature of Patient or Legal Representative Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Witness of Interpreter

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone No

\_\_\_\_\_  
Signature of Person Obtaining Consent

\_\_\_\_\_  
Date