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.