UCR | HEALTH

Form: 950-02-006-01

CONSENT FOR BEFORE-AND-AFTER PHOTOGRAPHS AND AUTHORIZATION FOR USE AND DISCLOSURE

Patient Name: _____

CONSENT TO PHOTOGRAPH; AUTHORIZATION FOR USE AND DISCLOSURE

I hereby consent to be photographed while receiving treatment at UCR Health. The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I hereby authorize the use of photographs by 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 Health faculty.

SPECIFIC AREA TO BE PHOTOGRAPHED / VIEWED

_____

_____

_____

_____

I consent to be photographed and authorize the use or disclosure of such photograph(s) in order to assist scientific, treatment, educational, public relations, marketing, news media, and charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold 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.

EXPIRATION

This Authorization will not expire.

This Authorization may be revoked only if photographs have not been published.

MY RIGHTS

I may request cessation of filming or recording at any time.

I may rescind this Authorization up until a reasonable time before the photograph is used, but I must do so in writing and submit it to:

University of California, Riverside
School of Medicine Compliance Office
900 University Avenue
Riverside, California 92521

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 or payment or eligibility for benefits.

I have a 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 understand that I will not receive any financial compensation.

SIGNATURE

Date:_____ Time:_____ AM / PM

Signature: _____
(patient/representative/spouse/financially responsible party)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(patient/representative/spouse/financially responsible party)

If this form is verbally translated please complete the following:

Translation to what language:_____

Name of translator or translation service: _____

Signature or ID#_____