CONSENT FOR PHOTOGRAPHY, VIDEO/AUDIO RECORDINGS AND/OR TO TELEVISE PATIENTS

(Images taken for the purposes of treatment, payment and/or health care operations)

Patient Name: ____

Last **First** **M.I.**

Date of Birth: ____________________ **UH Number:** ____________________

I consent to have my image taken by the staff of The University of Texas Medical Branch (UTMB) as described below:

I understand that my image, including photographs, digital images, video recordings, etc., will be recorded for the purpose of assisting in my care, documenting my treatment for payment reasons, and assisting in certain health care operations UTMB conducts including quality care initiatives. In addition, these images may be used to assist in the education of the students and residents **only within** UTMB.

For reasons other than treatment, payment, health care operations or education purposes as described above, I understand that UTMB will require me or my personal representative to sign a written authorization form in order to use or disclose my images.

I understand that UTMB will own these images, but I will be allowed to view them or obtain copies of them at a reasonable cost.

I certify this form has been fully explained to me. I have read it or have had it read to me, and I understand its contents. I agree to have my image taken by UTMB according to the conditions listed above.

______________________________________ ____________________

Signature of the Patient or Personal Representative Date

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PHOTOGRAPHY, VIDEO/AUDIO RECORDINGS AND/OR TELEVISED SESSIONS OF PATIENTS

(Images to be used or disclosed for purposes other than treatment, payment and/or health care operations)

Patient Name:

Last First M.I.

Date of Birth: **UH Number:**

1. The following information can be used and/or disclosed: *(check all that apply and provide a description)*
   - ❑ Photographs ____
   - ❑ Other digital images ____
   - ❑ Video/Audio Recordings _____________________________________
   - ❑ Other: ____
2. I authorize UTMB to disclose the information (as described above) to:

Name:

Address:

City, State, Zip **Telephone Number:**

3. If this authorization is for any purpose other than the release of PHI for personal reasons, please state the purpose below:

4. This authorization will expire on the 180th day of the signing or as otherwise specified below:

5. I understand this authorization is voluntary and I may refuse to sign. UTMB may not withhold treatment based on the completion of this authorization.
6. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care.
7. I understand that I may revoke this authorization at any time by notifying UTMB in writing to the Health Information Management Department, 301 University Blvd, Galveston, Texas 77555-0782 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by UTMB before UTMB received my written notice of revocation.
8. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws.

_____________________________________ ____________________

Signature of the Patient or Personal Representative Date