(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS
Medical Center

AUTHORIZATION to TAKE and RELEASE PATIENT PHOTOGRAPHS or VIDEO/AUDIO RECORDINGS

FOR STAFF TO COMPLETE BEFORE PATIENT SIGNS: **Dept/Clinic Name**_____ **and Slot #**_____

Person Making Photo/Recording _____ **Date Taken**_____ **(for initial photo/recording)**

(check all that apply) ☐ **Photographs** ☐ **Video Recordings** ☐ **Audio Recordings**

Description:_____

Location where image will be stored:_____

I, _____ hereby consent to the taking of photography, audio/visual recordings or other images of
Print Patient Name
me by UAMS. I understand that my photographs, videotapes, digital or other images may be used to assist with my identification, diagnosis and treatment and the payment of my bill. These images may also be used for UAMS Health Care Operations such as performance improvement and educational purposes within UAMS. I also give my permission and authorize UAMS** to make and **DISCLOSE** photographs or recordings described above to the public for educational, commercial, or other purposes as follows:

(PATIENT: Please strike through and initial any of the disclosures that you are not authorizing, if any).

1. UAMS internet website(s);
2. UAMS Posters, UAMS Publications, UAMS Photograph Books (by, on behalf of, or about UAMS);
3. Media, Internet Websites, Publications (TV, newspaper, magazine, any other media/websites outside UAMS); and
4. Healthcare-Related Presentations, Publications, Seminars, Conferences and Meetings (within and outside UAMS).
5. Other disclosures authorized, if any _____.

Additional Health Information Disclosed. I understand and agree that any photographs/recordings authorized by me may also disclose my Protected Health Information related to my **treatment, condition, procedure, surgery** or other Protected Health Information associated with the photographs or video/audio recordings, and **I authorize this disclosure.**

UAMS is **not** receiving direct or indirect compensation for use/disclosure of the phtographs/recordings described in theAuthorization.
Expiration Date - This Authorization expires **two years** from the date I sign the Authorization, or after the photographs and recordings are no longer needed by UAMS for the use and disclosure that I have authorized, whichever date is later.
Withdrawal of Authorization - I understand that I am not required to sign this Authorization. If I sign this Authorization, I may revoke/withdraw the Authorization at any time by giving written notice to UAMS [Dept/Clinic Above], Slot # [above], 4301 W. Markham, Little Rock, AR 72205. A withdrawal of this Authorization will not apply to records, information, photographs, audio/visual recordings or other information already used/released in reliance upon the Authorization. A photocopy or faxed copy of this signed Authorization shall constitute a valid authorization. **During the recording/filming, I have the right to stop recording/filming at any time.**
Release of Liability - I agree that UAMS, including its governing Board, physicians, agents and employees are hereby released from legal responsibility or liability for the access and release of my information to the extent indicated and authorized herein.
Re-Disclosure - I understand that once the above information is disclosed, it may no longer be protected by privacy laws.
UAMS will not condition treatment, payment, enrollment or eligibility for benefits on your signing of this Authorization.
****If patient is a patient of Arkansas Children's Hospital (ACH), the terms of this Authorization also include and extend to ACH.**

Signature of Patient or Legal Representative: _____ Date:_____ Time:_____
Patient Date of Birth and/or Medical Record Number for Identification purposes:_____
If Legal Representative has signed on behalf of Patient, state the authority of Legal Representative to do so:

_____
(such as parent of a minor, court-appointed guardian, appointed in a Power of Attorney)

APPENDIX B

Office Staff: Provide a copy of signed Authorization to Patient/Legal Representative