

Place Patient Label Here

Print Patient Name _____

Patient MR # _____

CONSENT to Take PHOTOGRAPHY

I, _____ hereby consent to the taking of photography, audio/visual recordings
Print patient name

or other images of 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. Other than for treatment, payment and health care operations, images that identify me will be released outside UAMS only upon written authorization from me or my legal representative.

If the images are to be taken for any purpose other than for identification, diagnosis, treatment, payment or healthcare operations including teaching with UAMS, the purpose(s) must be stated here:

Withdrawal of Consent – I understand that I am not required to sign this Consent. I may revoke/withdraw the Consent at any time by giving written notice to UAMS [Dept/Clinic below] Slot # [below], 4301 W. Markham, Little Rock, AR 72205. A withdrawal of this consent will not apply to photographs, audio/visual recordings or other images used or disclosed prior to the written notice of withdrawal. **During the recording or filming, I have the right to stop the recording/filming at any time.**

Expiration Date – This consent to take my photograph or other image expires 30 days from the date I sign the consent or after the photographs and recordings are no longer needed by UAMS for the use that I am consenting to, whichever is later.

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 photographs or other images to the extent indicated and authorized herein.

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)

For Staff use only - this section must be completed

FOR STAFF TO COMPLETE:

Dept/Clinic Name _____ **and Slot #** _____

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

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

Other: _____

Description: _____

Place Patient Label Here

Print Patient Name _____

Patient MR # _____

**AUTHORIZATION to TAKE and DISCLOSE
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: _____

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 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 or 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 photograph/recordings described in this Authorization.

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 _____

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)

Office Staff: Provide Copy of Signed Authorization to Patient/Legal Representative