(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

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:
In examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

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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: ______________________________

Location where image will be stored: ______________________________

Med Rec 1442 (11/29/17)
Consent