

MRN:
Patient Name:

(Patient Label)

CONSENT AND AUTHORIZATION FOR RELEASE OF PHOTOGRAPHS, FILMS, MEDICAL IMAGES, AND OTHER MULTIMEDIA FOR EDUCATIONAL PURPOSES

Faculty Member/Attending Name: _____

Department: _____ Telephone Number: _____

Purpose:

We ask your permission to take photographs, record films and/or create multimedia items that contain health information about you. The multimedia item will be taken or made during the course of a healthcare treatment you may receive from a UCLA Health System provider or at a UCLA Health System hospital or clinic. We want to share this information about you with other individuals and entities either inside or outside of UCLA Health System for educational purposes, so that other health sciences professionals and students can learn about your condition or disease. This will benefit other patients.

Confidentiality:

You will not be identified by your name. Other people may recognize your face or voice or other information that is unique to you. The multimedia item will be edited and stored on a computer without your name.

Notice:

UCLA and many other organizations and individuals such as doctors, nurses, dentists, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights:

You have the right to have the filming of photography stop at any time. Giving permission for us to use these items is voluntary. You may refuse to give permission without any penalty or loss of care or services. Your treatment, payment, enrollment and eligibility or benefits do not depend on your signing this permission form. If you have any questions about your rights, contact the Privacy Management Office, 10833 Le Conte Ave., Room BH-265, Los Angeles, CA 90075-7305, Telephone number (310) 825-5958.

Initials of Patient or Personal Representative: _____

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CONSENT AND AUTHORIZATION FOR RELEASE OF PHOTOGRAPHS, FILMS, MEDICAL IMAGES, AND OTHER MULTIMEDIA FOR EDUCATIONAL PURPOSES

Revoking your permission:

You may change your mind and withdraw your permission for use of the photographs, films or other materials at any time, without any penalty or loss of care or services. To revoke your permission, write a letter, sign it, and deliver it to the Privacy Management Office, 10833 Le Conte Ave., Room BH-265, Los Angeles, CA 90075-7305, Telephone number (310) 825-5958. The revocation letter will take effect when UCLA receives it, except to the extent that UCLA or others have already relied on it. If the multimedia items have already been shared, it may not be possible to recall them.

Expiration:

Unless you revoke your permission earlier, the Authorization expires on _____. If no date is indicated, this Authorization will expire fifty years after the date of your signing this form.

I give permission for these multimedia items to be taken or made or used:

Photographs: _____

Videos/films: _____

Audiotapes/audioclips: _____

Radiographs and other medical images: _____

Other multimedia items: _____

Health information regarding my medical condition or treatment to be released.
(please specify the health information you authorize for release):

Type(s) of health information: _____

Date(s) of Treatment: _____

Initials of Patient or Personal Representative: _____

MRN:
Patient Name:

(Patient Label)

CONSENT AND AUTHORIZATION FOR RELEASE OF PHOTOGRAPHS, FILMS, MEDICAL IMAGES, AND OTHER MULTIMEDIA FOR EDUCATIONAL PURPOSES

I give permission to UCLA to use these multimedia items for these educational purpose(s):

- Training of health science professionals at UCLA, including students, faculty and others in the David Geffen School of Medicine (for example, in classroom lectures, faculty presentations, student projects, laboratory manuals, and online curriculum materials).
- Sharing with (dissemination to) other health science center for use in their educational programs.
- Use in professional publications and presentations, textbooks and at professional conferences.
- Storage in libraries and repositories of teaching materials for the health sciences that are made available at no cost to the public, such as Health Education Assets Library (HEAL).

I specifically acknowledge that the information used or disclosed may include the following types of sensitive medical information:

_____ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment.

_____ I specifically authorize the release of information pertaining to mental health, diagnosis or treatment.

_____ I specifically authorize the release of HIV/AIDS test results.

Initials of Patient or Personal Representative: _____

I agree that UCLA will own any and all rights in the multimedia items listed above. I waive any and all rights that I may have in the use of my likeness, photograph, voice, or appearance in these multimedia items. UCLA will have the right to reproduce, distribute, sell, transmit, publish, exhibit, or otherwise use the multimedia items listed above. I will not receive any payment for any use of them.

I have read this paper about the use of multimedia items that contain my health information. I understand the permission I am giving. My questions have been answered to my satisfaction, and I agree to what this form says. I will get a copy of this form.

Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ ID # _____ Date _____ Time _____

Physician Signature _____ ID # _____ Date _____ Time _____