UCLA Health

AUTHORIZATION – PHOTOS, FILMS MEDICAL IMAGES & OTHER MULTIMEDIA

MRN:
Patient Name:

(Patient Label)

Faculty Member/Attending Name | Department | Telephone No.

Purpose:
We ask your permission to take photographs, record films and/or create multimedia items that contain health information about you. The multimedia items 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 health 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 items 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 or 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 for 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 90095-7305, telephone number (310) 825-5958.

Initials of patient or personal representative:_____

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 90095-7305, 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. It the multimedia items have already been shared, it may not be possible to recall them.

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

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

- o Type(s) of health information:_____
- o Date(s) of Treatment: _____

Initials of patient or personal representative: _____

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 sciences centers 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 the 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.

_____ I specifically authorize the release of genetic testing information.

Initials of patient or personal representative: _____

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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 permissions 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.

Signature of Patient or Legal Representative _____ Date _____ Time

Printed name of Legal Representative (if applicable) _____ Relationship to Patient (Parent, Guardian, Conservator, or Patient Representative)

Signature of Witness or Interpreter _____ Date _____ Time _____ Phone No.

Signature of Person Obtaining Authorization _____ Date _____ Time

Physician Signature _____ Date _____ Time

Patient Signature _____ Date _____ Time

Patient's Representative or Parent Signature _____ Date _____ Time