UCSF

UNIT NUMBER

PT. NAME

BIRTHDATE

DATE:	TIME:	LOCATION	DATE

CONSENT FOR PHOTOGRAPHY / AUTHORIZATION FOR PUBLICATION

I hereby give my consent for photography, filming, videotaping and/or audio recording or other means of capturing my image or voice and/or being quoted in the media or printed materials (including social media websites) at UCSF and hereby authorize release of such to:

_____

_____

Check one of the following:

I am a/an Patient ___(or) Patient's surrogate (legal representative) _____.

Staff ____, Volunteer____, Visitor ____, Other (describe) _____.

I authorize the use or disclosure of such for the following purposes ***(check all that apply):***

____ Research Activities (faculty, staff or vendors).

____ External Teaching (Publication in scholarly journals and textbooks; educational seminars, conferences and scientific exhibits/illustration; educational lectures to professional and public groups, etc.).

____ Marketing, Advertising and Media (Public Relations and charitable goals: UCSF publications and websites, printed materials, news reporting, documentary films, commercials, television or film, social media websites, etc.).

____ Other uses (describe): _____

THE FOLLOWING QUESTIONS ARE APPLICABLE TO PATIENTS ONLY:

Please specify the types of health information regarding your medical condition or treatment you authorize for release: _____.

Dates of Treatment: _____.

The following information will not be released unless you specifically authorize it by initialing the relevant line(s) below:

_____ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (24 C.F.R. Sections 2.34 and 2.35).

_____ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (W&I Code Section 5328).

_____ I specifically authorize the release of HIV/AIDS test results (H&S Code Section 120980(g)).

_____ I specifically authorize the release of genetic testing information (H&S Code Section 124980(j)).

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such disclosure may no longer be protected by state or federal confidentiality laws.

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

862-002A (Rev. 09/11) WorkflowOne ORIGINAL - MEDICAL RECORD COPY YELLOW - PATIENT COPY

UCSF

UNIT NUMBER

PT. NAME

BIRTHDATE

DATE:	TIME:	LOCATION	DATE

CONSENT FOR PHOTOGRAPHY / AUTHORIZATION FOR PUBLICATION

THE FOLLOWING IS APPLICABLE TO PATIENTS AND NON-PATIENTS:

I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold UCSF and its personnel and affiliated programs harmless from any and all liability which may or could arise from activities authorized by this agreement.

This authorization expires on _____. If no date given, authorization will expire 12 months after the date of signature of this form. Upon expiration of this Authorization, UCSF will not permit further release of any photography or information, but will not be able to call back any photography or information already released.

I may request cessation of filming or recording at any time. I may rescind this Authorization up until a reasonable time before the photography or information is used, but I must do so in writing.

I have a right to receive a copy of this Authorization.

UCSF will ___will not ____receive compensation for the use or disclosure of my photography or information. _____

UCSF Contact Information:

_____

PATIENT SIGNATURE:

Signature: _____ Date: _____

(patient or patient's surrogate)

If signed by someone other than the patient, indicate relationship:

_____

Print name: _____

(patient or patient's surrogate)

Contact Information (Name, address, phone number & email address):

_____

_____

Witness _____ Date: _____

Language: English ___ Other _____

Interpreter used (in person): ____ (telephone) ____

Interpreter Name (please print): _____

NON-PATIENT SIGNATURE:

Signature: _____ Date: _____

Witness _____ Date: _____

862-002B (Rev. 09/11) WorkflowOne ORIGINAL - MEDICAL RECORD COPY YELLOW - PATIENT COPY