UCSF
University of California
San Francisco

AUTHORIZATION AND CONSENT TO PHOTOGRAPH, PUBLISH AND RELEASE INFORMATION

I hereby give my consent to the University of California, San Francisco Medical Center (UCSF) and its medical providers and staff to photograph, film, videotape, audio record and/or use other means of capturing my image and/or voice. I authorize the use or disclosure of such for the following purposes ***(check all that apply):***

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

☐ Research Activities (faculty, staff or vendors)

☐ Other uses (describe):_____

Check one: I am a Patient ☐ (or) Patient's surrogate (legal representative) ☐

Note: The following information will <u>not</u> be released unless you specifically authorize it: Information pertaining to 1) the patient's name; 2) drug and alcohol abuse, diagnosis or treatment; 3) mental health diagnosis or treatment; 4) HIV/AIDS test results; 5) genetic testing information.

This authorization expires on _____ (Mo/Yr). 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, published, or included in educational materials. I may request cessation of photography, 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 waive any right to compensation. 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 hold UCSF and its providers and staff harmless from and against any claim for injury and or compensation resulting from the activities authorized by this authorization and consent.

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I have a right to receive a copy of this Authorization.

Print Name: _____ Date: _____

Signature: _____
(patient or patient's surrogate)

If signed by someone other than patient, indicate:	*If interpreter used, indicate:*
Relationship: _____	Name of interpreter: _____
Phone Number: _____	*Check one:* (in person): ☐ (telephone): ☐