Authorization to Interview, Photograph or Video Patient

PEMSource

I authorize the health care providers, including PEMSource.org, to include my child, _____, in photographs and videos related to emergency department care being provided, for internal and external audiences for the purposes of education and teaching. In addition to my/his/her likeness, I understand that information I approve about myself or my dependent may be included in the released information. Pictures or videos of my child undergoing the medical screenings or treatment may also be taken and published. I understand that PEMSource.org and the other health care providers do not control third party media sources or what they do with the information they obtain. This Authorization will expire when the pictures, videos, or materials are no longer in use.

Please note the following:

- Receiving care from any hospital, clinic or other facility is not conditioned on signing this Authorization. I or my dependent can still receive medical screenings and care even if this Authorization is not signed.
- I have the right revoke this Authorization at any time by sending a written request to PEMSource at pemsource@gmail.com. Note that revocation of the Authorization does not apply to any information that was properly released under this Authorization before we received your request to revoke it. However, at the time of revocation of Authorization, we will remove your child's images, video, and information from pemsource.org.
- Information used or disclosed based on this Authorization may be subject to redisclosure by the recipient and will no longer be protected by this Authorization or the privacy laws.
- You are entitled to a copy of the Authorization.

_____

Patient, Parent or Guardian Signature

_____

Date

_____

PEMSource Representative or other Witness

_____

Date

Parent and Patient Information

What is photo consent?

In simple terms, photo consent means you're giving permission for an image (picture) or video of your child to be used. If you would prefer, we can avoid showing your child's face. This could be for a website, lecture, TV program or more. In this particular instance, signing photo consent allows us to use your child's picture for educational purposes.

What will this picture/video be used for?

As stated above, pictures or videos can be used on their own, in lectures, or other educational modules. PEMSource.org is a website focused solely on education. Our goal is to provide a place for medical students, physicians and other healthcare professionals to come and learn more about medical issues and phenomena affecting children. Our goal is to educate so that healthcare professionals of all levels can provide the best possible care to infants and children.

Who can see this picture?

PEMSource.org is a public website. Anyone can access the general page, although there are areas that are password protected. If you consent to release a photo or video, please assume that it will be on the general website and viewable by anyone.

Thank you for helping us educate!

Harbor-UCLA MEDICAL CENTER

APPENDIX I

CONSENT TO PHOTOGRAPH AND AUTHORIZATION FOR USE OR DISCLOSURE

Patient Name: _____ **MRUN:** _____

Consent to Photograph; Authorization for Use and Disclosure

I hereby consent to be photographed while receiving treatment at the hospital. The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I hereby authorize the use of the photograph(s) by, or disclosure of the photograph(s) to:

_____

(Persons/Organizations authorized to receive the information)

_____

(Address – street, city, state, zip code)

Purpose

I hereby authorize the use or disclosure of the photograph(s) for the following uses or purposes (describe permitted uses, e.g., dissemination to hospital staff, physicians, health professionals, and members of the public for educational, treatment, research, scientific, public relations, marketing, new media, and charitable purposes):

_____

_____

I consent to be photographed and authorize the use or disclosure of such photograph(s) in order to assist scientific, treatment, educational, public relations, marketing, news media, and charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold the hospital, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

Expiration

This authorization expires (*insert date*): _____

Upon expiration of this authorization, this hospital will not permit further release of any photograph, but will not be able to call back any photographs or information already released.

My Rights

I may request cessation of filming or recording at any time.

I may rescind this authorization up until a reasonable time before the photograph is used, but I must do so in writing and submit it to the following address:

_____

I may inspect or obtain a copy of the photograph whose use or disclosure I am authorizing.

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.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

I understand that I will not receive any financial compensation.

If this box ☐ is checked, the hospital will receive compensation for the use or disclosure of my photograph(s).

Signature

Date: _____ Time: _____ AM / PM

Signature: _____

(patient/representative/spouse/financially responsible party)

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

Print name: _____

(representative/spouse/financially responsible party)

Harbor-UCLA MEDICAL CENTER

APPENDIX II

CONSENTIMIENTO PARA LA TOMA DE FOTOGRAFÍAS Y AUTORIZACIÓN PARA SU USO O DIVULGACIÓN

Nombre del Paciente: _____ **Número de Tarjeta:** _____

Consentimiento para la Toma de Fotografías; Autorización de Uso y Divulgación

Por la presente, doy mi consentimiento para que se me tomen fotografías mientras recibo tratamiento en el hospital. El término "fotografía" incluye video o fotografía fija, en formato digital o de otro tipo, y cualquier otro medio de registro o reproducción de imágenes.

Por la presente, autorizo el uso o la divulgación de la(s) fotografía(s) por parte de:

_____

(Personas/Organizaciones autorizadas a recibir la información)

_____

(Dirección: calle, ciudad, estado, código postal)

Propósito

Por la presente, autorizo el uso o la divulgación de la(s) fotografía(s) para los siguientes usos o propósitos (desciba los usos permitidos, p. ej., difusion al personal del hospital, médicos, profesionales de la salud y miembros del público con fines educativos, de tratamiento, de investigación, cientícos, de relaciones públicas, de mercadotecnia, de medios de comunicación y benéficos): _____

_____

Doy mi consentimiento para que se me tomen fotografías y autorizo el uso o la divulgación de tal(es) fotografía(s) a fin de contribuir con los objetivos científicos, de tratamiento, educativos, de relaciones públicas, de mercadotecnia, de medios de comunicación y benéficos, y por la presente renuncio a cualquier derecho a recibir compensación por tales usos en virtud de la autorización precedente. Por la presente, yo y mis sucesores o cesionarios eximimos al hospital, a sus empleados, a mi(s) médico(s) y a cualquier otra persona que participe en mi atención, y a sus sucesores y cesionarios, de toda responsabilidad ante cualquier reclamo por daños o de indemnización que surja de las actividades autorizadas por este acuerdo.

Vencimiento

Esta autorización vence el (*insertar fecha*): _____

Una vez que venza esta autorización, el hospital no permitirá posteriores divulgaciónes de mi fotografía, pero no podrá pedir que se devuelvan las fotografías o la información ya divulgadas.

Mis Derechos

Puedo solicitar que cese la filmación o grabación en cualquier momento.

Puedo rescindir esta autorización hasta una fecha razonable antes de que se utilice la fotografía, pero debo hacerlo por escrito y enviar la rescisión a la siguiente dirección:

_____

Puedo inspeccionar u obetener una copia de la fotografía cuyo uso o divulgación estoy autorizando.

Puedo negarme a firmar esta autorización. Mi negativa no afectará mi posibilidad de obtener tratamiento ni el pago o la elegibilidad para beneficios.

Tengo derecho a recibir una copia de esta autorización.

El destinatario podría volver a divulgar la información divulgada conforme a esta autorización. Tal nueva divulgación en algunos casos no está protegida por las leyes de California y podriá ya no estar protegida por la ley de confidencialidad federal (HIPAA).

Entiendo que no recibiré ningún tipo de compensación financiera.

Si esta casilla ☐ está marcada, el hospital recibirá compensación por el uso o la divulgación de mi(s) fotografía(s).

Firma

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente/representante/cónyuge/parte económicamente responsable)

En caso de que lo firmase una persona que no sea el paciente, indique la relación: _____

Nombre en letra de imprenta: _____
(paciente/representante/cónyuge/parte económicamente responsable)