UC Irvine Healthcare

Medical Record #

AUTHORIZATION FOR AND RELEASE OF PHOTOGRAPHS, SLIDES, AND/OR VIDEO FOOTAGE OF PATIENT IMAGES AESTHETIC AND PLASTIC SURGERY INST

Patient Name:

DOB:

Gregory R.D. Evans, MD, Mark Kobayashi, MD, Garrett A. Wirth, MD, Keyianoosh Paydar, MD, Daniel Jaffurs, MD, PhD, Al Aly, MD , Jason Toranto, MD
Telephone No. 714-456-3077

Purpose: I consent to the taking of photographs, slides, recording of films and/or creation of multi-media items of parts of my body in connection with the plastic surgery procedure(s) to be performed by the above mentioned physician. I authorize the use and disclosure of the photographs and images of me for the following purposes:

✓ Training of health sciences professionals at UC Irvine, including students, faculty and others in the UC Irvine School of Medicine (for example 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 society publications, medical journals, presentations, medical textbooks and at professional conferences for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods

✓ Storage in repositories and databases of teaching materials for the UC Irvine Aesthetic Plastic Surgery Institute

✓ Inclusion in brochures and other advertisements about the UC Irvine Aesthetic & Plastic Surgery Institute

✓ I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

☐ Other: _____

*Initials of Patient or Personal representative:*_____

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Confidentiality: I understand that I will not be identified by name. I understand that in some circumstances, the images may portray features that will make my identity recognizable.

> *Notice:* UC Irvine 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. I understand that if I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, such as the ASPS or the ABPS, it may no longer be protected by state or federal confidentiality laws.

Your Rights: I understand that I have the right to have the filming or photography stop at any time. Giving permission for us to use these items is voluntary. I may refuse to give permission without any penalty or loss of care or services. My treatment, payment, enrollment and eligibility for benefits do not depend on my signing this permission form. If I have any questions about my rights, I may contact the Health Information Management Office, 101 City Drive, Rte 118, Bldg 25, Orange CA 92868, telephone number 714-456-5670.

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

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):

- Type(s) of health information:_____

✓ Date(s) of treatment: _____

*Initials of Patient or Personal representative:*_____

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Patient Name:

DOB:

Revoking Your Permission: I understand that I may change my mind and withdraw my permission for use of the photographs, films or other materials at any time, without any penalty or loss of care or services. To revoke my permission, I must write a letter, sign it and deliver it to the Health Information Management Office, 101 City Blvd, Rte 118 Bldg 25, Orange, CA 92868; telephone number (714) 456-5670. The revocation letter will take effect when UC Irvine receives it, except to the extent that UC Irvine or others have already relied on it. If the multimedia items have been shared, it may not be possible to recall them.

I agree that UC Irvine will own any and all rights in the multimedia items listed above. I waive any and all right that I may have in the use of my likeness, photograph, voice or appearance in these multimedia items. UC Irvine 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 consent 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 consent.

Signature of Patient or Legal Representative	Date
Printed name of Legal Representative (if applicable)	Relationship to Patient (Parent, Guardian, Conservator, or Patient Representative)
Signature of Witness or Interpreter	Date / Telephone No.
Signature of Person Obtaining Consent	Date

*Initials of Patient or Personal representative:*____

Original – Medical Record, 2nd copy patient, 3rd copy Faculty Member