Patient Label

UC Irvine Health

Plastic Surgery Photo Consent

AUTHORIZATION FOR AND RELEASE OF PHOTOGRAPHS, SLIDES, AND/OR VIDEO FOOTAGE OF PATIENT IMAGES – UCI Plastic Surgery and the following physicians:
Gregory R.D. Evans, MD, Mark Kobayashi, MD, Brock Lanier, MD, Raj Vyas, MD
Daniel C. Jaffurs, MD, Amber R. Leis, MD, Cathy Tang, MD, Eric Wang, MD

THIS IS A 2 PAGE DOCUMENT. DO NOT SIGN IT UNLESS YOU HAVE READ AND UNDERSTOOD ALL THE PAGES. SIGNING THIS DOCUMENT IS PURELY VOLUNTARY. IF YOU ELECT NOT TO SIGN THIS DOCUMENT YOU WILL STILL BE ENTITLED TO AND RECEIVE THE SAME CARE AND TREATMENT.

I am a patient of UC Irvine Health and am undergoing treatment with Dr. _____

1. **Purpose:** In connection with my treatment by Dr. _____ I consent to the taking of photographs, slides, recordings of films and /or creation of multi-media items of parts of my body related to the plastic surgery procedure(s) to be performed by the above mentioned physician. By my initialing and signature below, I hereby authorize the use and disclosure of de-identified photographs and images of me for the following purpose

- ✓ 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). (initials) _____
- ✓ 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 Plastic Surgery. _____
- ✓ Inclusion in brochures and other advertisements about the UC Irvine Plastic Surgery. _____
- ✓ Posting of deidentified (eyes blacked out and no names) before and after photographs of my body on social and electronic media, including, but not limited to, the internet and websites. _____

My initials below signify my permission for these multimedia items to be taken or made and used as described above. Failure to specifically initial any of the below will indicate that you decline to authorize use of your likeness or photograph(s) in the specified category:

- ✓ Photographs_____
- ✓ Videos/films:_____
- ✓ Audiotapes/audio clips:_____
- ✓ Radiographs and other medical images:_____ _____
- ✓ Other multimedia items:_____
- ✓ Date(s) of treatment:_____
- ✓ Other _____
- ✓ Social Media: _____
- ✓ Health information regarding my medical condition or treatment to be released (please specify the health information you authorize for release): _____

*Initials of Patient or Personal representative*_____

2. **Confidentiality**: I understand that I will not be identified by name or any other means of identification (date of birth, medical record number) in any photos or other representations of me enumerated in paragraph 1. All efforts will be made to completely de-identify me on any photos or images, representations of me that are used as described above, however, I understand that in some circumstances, the images, in addition to other information, may portray such features/information that will allow a third person to recognize me.

Notice: UCI 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 American Society of Plastic Surgery or the American Board of Plastic Surgery, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS: I understand that I have the right to request the filming or photography stop at any time. If I give permission, it is voluntary and, I understand that I may change my mind and withdraw my permission for use of 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 The City Drive, 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 my prior permission has already resulted in the sharing of such information. I understand that in such a situation, if the multimedia items have shared, it may not be possible to recall them. However, there will be no additional disclosures. I further understand I am entitled to a complete listing of any disclosures/release of multimedia items upon my request.

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 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 that 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 or Legal Reprsentative (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*_____