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| CORE DATA • AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION FOR A STANFORD UNIVERSITY MEDICAL CENTER COMMUNICATIONS OR MEDIA-RELATIONS ACTIVITY  Page 1 of 7 | Medical Record Number  Patient Name  Addressograph or Label |

**STANFORD UNIVERSITY MEDICAL CENTER**

**Stanford Hospitals & Clinics**

**Lucile Packard Children’s Hospital**

**Stanford University School of Medicine**

**CONSENT TO PHOTOGRAPH, AND**

**AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION**

**FOR COMMUNICATIONS OR MEDIA-RELATIONS PURPOSES**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please print)

**MRN#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

X

🞎 A representative from the Stanford University Medical Center communications staff will be photographing you

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**Title of Media Activity**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Media Activity**

**CONSENT TO PHOTOGRAPH**

By your signature below, you authorize the individual identified above to photograph you, take television pictures of you, take videotapes of you, and/or make electronic recordings of you (hereafter referred to as photographic or electronic reproductions) while under care at the Medical Center, or participating in a Medical Center program. The term “photograph” includes video or still photography, in digital or other format, and any other means of recording or reproducing images. This consent includes the taking of photographic or electronic reproductions of any part of your body.

I understand that I may refuse to consent to the taking of any photographs that are not necessary to my/the patient’s treatment, operation or procedure without prejudice to my/patient’s care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

(Signature of Patient/Personal Representative) Date

If signed by someone other than the patient, state your legal relationship to the patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this document was translated:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Interpreter)

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_ Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR USE AND DISCLOSURE OF PHI**

SHC/LPCH/SoM understands that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information (PHI) for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

A communications representative from Stanford University Medical Center must fully answer any questions you may have regarding this form. DO NOT SIGN A BLANK FORM. You[[1]](#footnote-1)\* should carefully read the descriptions below before signing this form.

Additionally, you agree to obtain written approval from Stanford University Medical Center to use any photographs taken by you or your friends or family members at the Medical Center for any commercial or business purpose outside of personal use.

**Who will disclose the information?**

□ SUMC and its affiliates. Health information about you that is disclosed or used for a Stanford University Medical Center communications or media-relations activity will be obtained only from you and/or those involved in your care at Stanford University Medical Center

X

□ Other Individuals

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who will use and/or receive the information?** Your health information will be received by a

□ Communications representative from the Stanford University Medical Center and may be used or disclosed as specified in the following section, or

□ Other Individual \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What information will be used or disclosed?** General information about you, including but not limited to the following:

□ Medical information and photographs related to your medical care or condition, within the context of media-related inquiry

X

□ External appearance (e.g., photographic images)

X

□ Only the following information can be released (please be specific):

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the purpose of the use or disclosure?** The health information described above may be used for the following communications or media-relations activity(ies). You agree to participate in an interview, to provide facts about your care and treatment, and/or to have photographs, audio, video or film recordings made of you or made during a procedure involving you at Stanford University Medical Center or Stanford University, for:

□ Stanford University or Stanford University Medical Center publications, such as: Packard Pulse Stanford Medicine

X

Your Child’s Health Inside Stanford Medicine

Physician Update Medical Staff Update

Stanford Medicine News Stanford Report

□ Stanford University or Stanford University Medical Center's public website(s)

X

□ Stanford University Medical Center’s disclosure for future publication in the media including, but not limited to, newspaper, television, radio, magazines, Internet publications, etc.

X

□ Lucile Packard Foundation for Children’s Health, Stanford University Office of Medical Development, and/or Stanford University Office of Development for fundraising or other promotional purposes

X

□ Marketing/advertising by Stanford University Medical Center, including possible use in a photo or video archive for future medical center promotional purposes.

X

□ Other SUMC purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ External media activity/organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When will this authorization expire?** This authorization expires at the termination of the specific communications or media-relations activity in which you have agreed to participate, or on January 1, 2158, whichever is longer. *For example, by agreeing to have your health information used and disclosed in a Stanford University Medical Center newsletter or other internal publication, you are authorizing Stanford University Medical Center to continue to distribute that newsletter or publication until the information contained therein is no longer relevant or useful to Stanford University Medical Center’s communications operations.*

Following the expiration of this authorization, no further use or disclosure of your health information, photographs, audio, video or film recordings will be made by Stanford University Medical Center, unless authorization for such additional use or disclosure has been expressly provided by you or your personal representative. **Please be advised that following a Stanford University Medical Center communications or media-relations activity, or if this authorization pertains to an external media-relations activity, your health information may be picked up and then reprinted and/or rebroadcast and disclosed by other people, entities and media who are not connected to Stanford University Medical Center.** *For example, Stanford University Medical Center cannot limit the amount of time the media may use footage or photographs for future print publications and broadcasts. Also, despite Stanford University Medical Center’s copyright, it cannot limit or control outside websites or Internet aggregation sites that republish information and images taken from the Medical Center’s websites.*

**Can I revoke this authorization?** You can revoke this authorization at any time BEFORE we have relied upon it, but we may use and disclose your health information to the extent that we have relied upon your authorization. Our reliance on your authorization begins as soon as the Stanford University Medical Center’s communications staff has completed the work-product that is the subject of the communications or media-relations activity. *For example, in the case of a Medical Center newsletter, you can revoke your authorization to have your health information published in that newsletter at any time before that newsletter has been printed. Anytime thereafter you may no longer revoke your authorization, as we will have submitted the completed newsletter to the printers in reliance on your authorization.*

Because the Stanford University Medical Center’s communications staff puts a great deal of time, energy and resources into conceiving and developing communications/media-relations activities, we ask that you write to us at the following address as soon as possible after having decided to revoke your authorization:

Office/Department: SUMC Office of Communication & Public Affairs

Address: 555 Middlefield Road, Building 110

City, State, ZIP: Menlo Park, CA 94025

Attention: Director, Print and Web Communications

**SPECIFIC UNDERSTANDINGS**

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. You should note that when your protected health information is disclosed to people or entities that are not required to abide by federal or state medical privacy laws, those people or entities may re-disclose your information to others and use your information without being subject to penalties under those laws.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care and your health-care benefits will not be affected if you do not sign this form.

You also have a right to receive a copy of this form after you have signed it.

**SIGNATURE**

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority

If this document was translated:

.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ SIGNATURE (Interpreter) Date Time Language

CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form must be filled in below.

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| --- | --- |
| Address:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Telephone:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(daytime)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(evening)  E-mail Address (optional):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

***A COPY OF THIS FORM MUST BE PROVIDED TO THE PATIENT OR TO HIS/HER PERSONAL REPRESENTATIVE AFTER IT HAS BEEN SIGNED***

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For Internal Use Only:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of communications representative who completed form

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

1. \**“You” in this authorization means a patient or, if applicable, the patient’s personal representative. A personal representative is any person authorized to act on behalf of the patient with respect to his/her health care. For example, a personal representative may include the parent or guardian of a minor (unless the minor has the authority under California law to act on his/her own behalf), the guardian or conservator of an adult patient, or the person authorized to act on behalf of a deceased patient.* [↑](#footnote-ref-1)