MUSC Health

CONSENT

PATIENT CONSENT TO PHOTOGRAPHY / VIDEOTAPE / FILM / INTERVIEW

Form Origination Date: 10/04
Version: 3 Version Date: 11/11

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

Patient Name:	**Date of Birth:** **Medical Record Number:**
Person(s) or Class of Persons Authorized to Use / Disclose the Information:	**Person(s) or Class of Persons Authorized to Receive the Information:**

Patient consents to be:
☐ Photographed ☐ Filmed ☐ Videotaped ☐ Interviewed
☐ Other:

Purpose of Use / Disclosure:
☐ Publication in newspaper(s), magazine(s) or other publications
☐ Broadcast by radio or television
☐ MUSC / MUSC Medical Center / UMA marketing and public relations materials or publications
☐ Educational purposes, to include publication in medical literature
☐ Medical care
☐ Other:

Description of Protected Health Information to be Used or Disclosed:
☐ All Patient Identifying Information ☐ Age / Date of Birth ☐ Address
☐ Nature of Illness or Injury ☐ Other: _____
☐ Not Applicable

I understand that, when external sources such as local or national media are involved, MUSC / MUSC Medical Center / UMA is acting only as the intermediary. Release of information to these source(s) will allow them to contact me.

I further relieve and hereby agree to hold harmless the Medical University of South Carolina, MUSC Medical Center, and UMA or any of their subsidiaries or affiliates from any and all claims or liability arising out of the use and/or release of information; interview; photograph / videotape / film and subsequent publication or broadcast. I understand that the interview(s) or photo session(s) are being carried out upon my consent and authorization and I assume full responsibility for that content.

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and payment for my health care will not be affected.
3. I may revoke this authorization any time in writing. If I do, it will not have any effect on actions taken prior to receiving the revocation. Written revocation must be forwarded to _____.
4. If the individual or organization requesting or receiving the information is not a health plan or health care provider, the released information may be redisclosed by the recipient and may not be protected by federal privacy regulations.
5. I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I will not receive any money or other remuneration now or in the future as a result of my signing this authorization and I waive any interest in same.
7. Information may be released without my consent if required by state or federal law or regulation.
8. If I have questions about this form or use of the information, I may contact the Privacy Officer at 843-792-7795, 843-792-4037, 843-876-1321 or _____.
9. I will receive a copy of this form after I sign it.

This authorization will expire on the following: (check and complete only one box)
☐ **Date:** ☐ **Event:** ☐ **1 year from date signed**

I have read the above and authorize the disclosure of protected health information as stated:

Signature of Patient/Guardian/Patient Representative or Employee/Volunteer/Physician:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

Original to Medical Record Copies to Public Relations and Patient