The University of Texas Health Science Center at San Antonio

Consent for Photography

Patient Name: _____ **DOB:** _____ **MRN#:** _____

Parent or Legal Guardian: _____

I consent to have my (or child or an individual to whom I provide guardianship) image to be taken by the staff at _____ _____ as described below.

I understand that my (or child or an individual to whom I provide guardianship) photographs, videotapes, digital, and other images may be recorded to document and assist with my care and the payment of my (or child or an individual to whom I provide guardianship). These images may be used to assist in the education of students and residents within the institution. I understand that The University of Texas Health Science Center at San Antonio will own these images, but that I will be allowed access to view them or to obtain copies of them at a reasonable cost. Other than for treatment, education, and payment purposes, images that identify me (or child or an individual to whom I provide guardianship) will be released and/or used outside the organization only upon written authorization from me or the patient representative.

Purpose of the disclosure for any purpose other than treatment, education, or payment purposes: _____

_____

Dates of Treatment: From: _____ To: _____

I may revoke or withdraw this consent at any time. Unless revoked earlier, this consent expires in <u>one</u> year unless I specify another time period: _____. Withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

I release and hold harmless The University of Texas Health Science Center at San Antonio, its staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the photograph or other image.

By signing below, I am indicating that I have read and understand the "Consent for Photography" form. I am either the patient or have the authority to give consent for the patient. My questions regarding this consent have been answered.

_____ _____

Patient or Patient Representative Signature) Date

_____ _____

If Patient Representative, Relationship to Patient Printed Name