1. **PURPOSE:** To establish guidelines for photographing, videotaping, audiotaping and/or filming patients.

2. **PHILOSOPHY:** It is our belief that any photographing, videotaping, audiotaping, and/or filming of patients be done in a manner consistent with a patients' privacy rights.

3. **ASSOCIATED INFORMATION:**
   3.1. **Background Information:** Certain procedures are routinely videotaped or photographed at the request of the physician (both employed by the UABHS, or affiliated with other UABHS entities via Medical Staff appointment) or other UAB Health System employees. Indications may include, but are not limited to, identification, patient treatment, and/or student/staff education. In the other instances, physicians may desire to have patients and/or procedures videotaped or photographed for purposes of research, publication or other reasons.

4. **STANDARDS:**
   4.1. **For Treatment and Healthcare Operations.** Consent shall be obtained prior to any photographing, videotaping, audiotaping, and/or filming of patients for treatment or healthcare operations, including student/staff education.
      4.1.1. The physician or other health care professional requesting/initiating the photographing, videotaping, audiotaping and/or filming of a patient shall obtain the patient’s prior consent.
      4.1.2. The patient’s consent shall be documented on the consent for the procedure being performed or on Consent to Photograph, Publish or Video Taping (Attachment A).
   4.2. **For Research.** Photographing, videotaping, audiotaping, and/or filming of patients for research must be done pursuant to a research protocol reviewed and approved by the UAB Institutional Review Board.
   4.3. **By Media and External Entities.** Photography, videotaping and/or filming of patients by media (UAB or external) and other external entities shall be permitted only when Authorization for Release (Attachment B) has been executed by the patient and approval has been granted by Hospital administration or their designee.
      4.3.1. Staff/faculty shall contact Media Relations whenever media requests access to faculty/staff/patients.
4.3.1.1. Media Relations or their designee shall be responsible for obtaining patient Authorization.
   4.3.1.1.1. Patient's original Authorization form shall be maintained in patient's medical record
   4.3.1.2. External media shall be accompanied by UAB Media Relations or designee.
   4.3.1.3. UAB Media Relations or other administration representative shall obtain written agreements stating any limitations/restrictions on use of film.

4.4. The patient shall have the right to request cessation of recording or filming.
   4.4.1. A patient shall have the right to rescind consent for use of the photographs and/or audiotape by submitting a written request to UAB. However, any actions taken by UAB with regard to use of the recording or film prior to the rescission will not be affected.

4.5. All staff shall be vigilant for the presence of cameras and/or audiotape machines within the institution.
   4.5.1. Photographs videos, audiotapes and/or filming of a patient by a family member or other individual for use by the patient/family shall not be permitted in areas where the potential of capturing another patient's image exists.
   4.5.2. Photography, videotaping and/or filming/audio taping shall not occur during cardio-pulmonary resuscitation or other emergent situations.
   4.5.3. Cameras/audio taping machines are not allowed on patient care units within the Center for Psychiatric Medicine.
   4.5.4. Photography, videotaping and/or filming/audio taping shall not occur during the course of vaginal or cesarean section deliveries.
   4.5.4.1. Before and after the delivery of the infant, family members may audio or videotape at the discretion of the caregivers and the physicians. Patient care must not be compromised in order to permit audio or videotaping.
   4.5.4.2. Video that exposes the patient's perineum, abdomen, or breast shall not be allowed.
   4.5.5. Photography, videotaping and/or filming/audio taping shall not occur during invasive procedures such as circumcisions or epidural placement.
   4.5.6. Photography, videotaping and/or filming/audio taping of staff for purposes other than those stated in 4.1, 4.2 and 4.3 of this policy shall be prohibited unless approved by Risk Management.
   4.5.7. If a conflict arises regarding video or audio taping, UAB Police shall be notified.

4.6. Photographing deceased infants in Women’s & Infants’ Services shall be performed only after written consent has been obtained on the Bereavement Consent to Photograph, from parent or guardian contained in Attachment C.
   4.6.1. Prepared prints will be provided to mother or designated family member of the deceased upon request by the method of their choice which may include hand delivery or by mail.
   4.6.2. Any film negatives, disks or prints not in possession of the family will be kept in conformance with the "Records Management Policy".

4.7. UAB Health System shall fully cooperate with law enforcement officers acting in the course of an official investigation to include photographing, videotaping and/or filming/audio taping.

5. REFERENCES: None

6. SCOPE: This standard applies to all areas of the Health System.

7. ATTACHMENTS:
   Attachment A: Consent to Photograph, Videotape, Audiotape and/or Film
   Attachment B: UAB Health System Authorization for Use or Disclosure of Information
Attachment C: Callahan Eye Foundation Hospital Authorization for Use or Disclosure of Information
Attachment D: Women’s & Infants’ Services Bereavement Consent to Photograph

**INTERDISCIPLINARY COLLABORATION**

<table>
<thead>
<tr>
<th>UAB Health System Committees</th>
<th>Date Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician / Medical Committees</th>
<th>Date Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Committees / Councils</th>
<th>Endorsement Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathleen Kauffman, Legal Council</td>
<td>02/08/05</td>
</tr>
<tr>
<td>Patricia Pritchett, Legal Council</td>
<td>11/23/04</td>
</tr>
</tbody>
</table>

**UAB Hospital**
- Deborah Grimes, JD, RN, Dir., JCAHO & Regulatory Affairs | 02/07/05

**TKC**
- Marty Box, HR Director | 02/07/05
- Penny Phillips, Director, Clinical and Systems Integration | 02/07/05

**CEFH**
- Libby Bailey, CFO | 02/07/05
- Lynne Lanier, Asst Vice President, Patient Care Services | 02/08/05
- Karen Burleson, Asst Vice President, Human Resources/Risk Management | 02/09/05
- Louis Duhe’, Asst Vice President, Ancillary & Support Services | 02/07/05
- Anne Banks, CEFH Public Relations | 02/14/05

<table>
<thead>
<tr>
<th>Department(s)</th>
<th>Endorsement Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scott Buchalter</td>
<td>03/31/05</td>
</tr>
</tbody>
</table>
- Scott Buchalter, MD, Chief of Staff, UAB University Hospital | Date |

| Michael Waldrum | 04/05/05 |
- Mike Waldrum, MD, Chief Operating Officer, UAB Hospital | Date |
| David Hoidal | 05/02/05 |
- David Hoidal, Executive Director, The Kirklin Clinic | Date |
| Raymond Butler | 03/07/05 |
- Raymond Butler, President, Callahan Eye Foundation Hospital | Date |

| Nancy Dunlap | 04/08/05 |
- Nancy Dunlap, MD, Chief of Staff, The Kirklin Clinic | Date |
| Robert Morris | 03/14/05 |
- Robert Morris, MD, Chief Staff, Callahan Eye Foundation Hospital | Date |

**Tracking Record**

<table>
<thead>
<tr>
<th>Action</th>
<th>Reasons for Development/Change of Standard</th>
<th>Change in Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developed</td>
<td>Reformatted</td>
<td>Reviewed</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Supersedes: Consent to Photograph, Videotape or Film, 10/21/02, 09/06/04

File Name: Consent to Photograph, Videotape, Audiotape or Film # 510r2

REVISIONS: Consistent with JCAHO Standards, this standard is to be reviewed at least every 3 years and/or as practice changes.
Consent to Photograph, Videotape, Audiotape and/or Film

The undersigned (Patient) does hereby agree and authorize UAB Health System Operating Entities including UAB University Hospital; University of Alabama Health Services Foundation and its The Kirklin Clinic and other owned and operated clinics; Callahan Eye Foundation Hospital; and University of Alabama Ophthalmology Services Foundation and all respective employees, agents, directors, and trustees, hereafter known as “Health System” to photograph, video tape audiotape and/or film ________________________________ while under the care of a Health System facility or clinic for purposes of diagnosis, treatment, and healthcare operations, including education and teaching.

The undersigned (Patient) and his or her heirs or next-of-kin do hereby relinquish all rights and privileges to all aforementioned negative(s), print(s), audiotapes and/or video recording(s) while relinquishing all current and future rights and interests for the purposes contemplated herein.

Signed on this the ________ Day of ___________ in the year _______________.

____________________________________
Patient or Legal Guardian

____________________________________
Print Name of Patient or Legal Guardian

____________________________________
Witness
UAB HEALTH SYSTEM – University of Alabama Hospital, The Kirklin Clinic, The Kirklin Clinic at Acton Road, UAB Health Centers, the University of Alabama Health Services Foundation P.C. (Health Services Foundation), Callahan Eye Foundation Hospital and community physicians who are on the UAB Health System Medical and Dental Staff pursuant to the UAB Health System Medical and Dental Staff Bylaws.

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information (“PHI”) as described below. This Authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists or records pertaining to sexually transmitted diseases, if they are a part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to redisclosure and no longer be protected by federal privacy regulations.

Patient name: ________________________________ Medical Record Number: ____________________
Patient SSN: ______-____-__________ Patient DOB: _____ / ____ / _____________
Patient’s Phone #: (______)_________________ City, State, Zip: ____________________________

Persons/organizations providing the information:
Name: ____________________________________ Name: _______________________________
Address: __________________________________ Address: ______________________________
City, State, Zip: _____________________________ City, State, Zip: _______________________

Persons/organizations receiving the information
Name: ____________________________________ Name: _______________________________
Address: __________________________________ Address: ______________________________
City, State, Zip: _____________________________ City, State, Zip: _______________________

Specific description of information (including date(s)):
___ Face Sheet _____________________________ ___ Discharge Summary _______________________
___ History and Physical ____________________ ___ Pathology report ___________________________
___ Emergency room record __________________ ___ Diagnostic procedure report(s) (dates & types)
___ Lab report(s) (dates) _____________________ ___ Problem list _____________________________
___ Medication list __________________________ ___ X-ray report(s) (dates) _____________________
___ Clinic notes _____________________________ ___ Operative report(s) (dates) __________________
___ Consultation reports from (please supply physicians name):
___ Other: (please describe):

Purpose of Use or Disclosure:
This information for which I’m authorizing disclosure will be used for the following purpose:
___ My personal records _____________________ ___ Other: (please describe):
___ Sharing with other health care providers as needed ________________________________

UAB Health System Interdisciplinary Standard: Consent to Photograph, Videotape, Audiotape or Film
The patient or the patient's representative must read and initial the following statements:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the entity privacy coordinator. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Initial: __________ I understand that I may revoke this Authorization at any time by notifying the UABHS Privacy Officer in writing, but if I do, it will not have any affect to the extent UABHS took action in reliance on the Authorization.

Initial: __________ I understand that UABHS may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on signing this Authorization, except under the following circumstances:

• Participating in research projects can be conditioned on my signing an Authorization to use and disclose PHI in the research
• Initial enrollment in health plans can be conditioned on signing an Authorization for the health plan to review PHI to make eligibility determinations
• Furnishing healthcare services to me at the request of a third party can be conditioned on me signing an authorization for disclosure of the PHI to the third party requesting the treatment

This authorization will expire _____________________________.

(date of event)

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

Signature of patient or patient’s representative: ________________________________

Printed Name of patient: ____________________________________________________

Printed Name of patient’s representative: ______________________________________

Relationship to the patient: _________________________________________________

Date: _____________________________

Office use only:

Distribution copies: Original to provider; copy to patient; copy to accompany use or disclosure

Use or Disclose Health Information

Patient Name: ________________________________

Medical Record Number: ______________________________

Date of Birth: ________________________________
I hereby authorize the use or disclosure of my individually identifiable protected health information (“PHI”) as described below. This Authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists or records pertaining to sexually transmitted diseases, if they are a part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to redisclosure and no longer be protected by federal privacy regulations.

Patient name: ____________________________  Medical Record Number: __________________________
Patient SSN: ______-____-__________  Patient DOB: _____/_____/__________
Patient’s Phone #: (_____)______________  Patient’s Address: ____________________________

Persons/organizations providing the information:
Name: ____________________________  Address: ____________________________
City, State, Zip ____________________________  Phone: ____________________________

Persons/organizations receiving the information:
Name: ____________________________  Address: ____________________________
City, State, Zip ____________________________  Phone: ____________________________

Specific description of information (including date(s)):
___ Face Sheet  ___ Discharge Summary
___ History and Physical  ___ Pathology report
___ Emergency room record  ___ Diagnostic procedure report(s)
___ Lab report(s) (dates)  ___ (dates & types)
___ Medication list  ___ Problem list
___ Clinic notes  ___ X-ray report(s) (dates)
___ Consultation reports from (please supply physicians name):  ___ Operative report(s) (dates)
___ Other: (please describe):

Purpose of Use or Disclosure:
This information for which I’m authorizing disclosure will be used for the following purpose:
___ My personal records  ___ Other: (please describe):
___ Sharing with other health care providers as needed
The patient or the patient’s representative must read and initial the following statements:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the entity privacy coordinator. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Initial: __________ I understand that I may revoke this Authorization at any time by notifying the UABHS Privacy Officer in writing, but if I do, it will not have any affect to the extent UABHS took action in reliance on the Authorization.

Initial: __________ I understand that UABHS may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on signing this Authorization, except under the following circumstances:

• Participating in research projects can be conditioned on my signing an Authorization to use and disclose PHI in the research
• Initial enrollment in health plans can be conditioned on signing an Authorization for the health plan to review PHI to make eligibility determinations
• Furnishing healthcare services to me at the request of a third party can be conditioned on me signing an authorization for disclosure of the PHI to the third party requesting the treatment

This authorization will expire __________________________.  
(date of event)
If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

Signature of patient or patient’s representative: ________________________________________________

Printed Name of patient: _____________________________________________________________

Printed Name of patient’s representative: ________________________________________________

Relationship to the patient: ___________________________________________________________

Date: ______________________________

Office use only:

Distribution copies: Original to provider; copy to patient; copy to accompany use or disclosure

Use or Disclose Health Information

Patient Name: ____________________________________________________________

Medical Record Number: _________________________________________________

Date of Birth: ____________________________________________________________
Attachment D:

Women’s & Infants’ Services Bereavement
Consent to Photograph

The undersigned authorizes designated staff of Women’s & Infants’ Services at the UAB Hospital to photograph _____________________________ (deceased) and agrees that those persons will issue the prepared photograph prints to the mother or designated family member of the deceased.

Check one of the following options:

1. _____ Option# 1 I request the photographs be mailed to the following address:
   ATTN: ______________________________________________________
   ADDRESS: __________________________________________________
   ____________________________________________________________
   CITY: ________________________ STATE: ________ ZIP: __________
   Phone number: ______________________________________________

2. _____ Option# 2 I or my designee, ___________________________, will pick up the photographs.
   Phone number: ______________________________________________

3. ____ Option# 3 I DO NOT wish to have these photographs at this time, but request they be held by UAB until a time in which I may request them up to 1 years time.

Any film negatives, disks or prints not in possession of the family will be kept in a secured place and retained and destroyed in accordance with the Records Management Policy.

____________________________________  ______________________
Signature                        Date

____________________________________
Print Name

____________________________________  ______________________
Witness                        Date

F# 188r2 (Ref # 510r2) Developed: 3/4/01 Revised: 9/18/03 Approved: 02/07/05

UAB Health System Interdisciplinary Standard: Consent to Photograph, Videotape, Audiotape or Film