



**Health System
INTERDISCIPLINARY STANDARD**

Title: <i>Consent to Photograph, Videotape, Audiotape or Film</i>		
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Endorsed: <i>See Interdisciplinary Collaboration</i> Date	Endorsed: NA Date	Pages 1 of 9 Written 02/07/01 Reviewed 11/23/04 Revised 02/07/05 Issued 05/02/05
Approved: <i>David Hoidal</i> 05/02/05 David Hoidal, CEO UAB Health System Approval	Approved: NA Date	
JCAHO Ref#: RI.2.10, RI.2.30, RI.2.40 (2004)		Discontinued:
Associated Diagnosis/- Cross-References (CR):	<i>*Bereavement (Infant Death) Care (CR)</i> <i>*Paper & Video Records, Release of HS#19 (CR)</i> <i>*Copy of Seizure Monitoring Video for Patient CN# 3 CR</i> <i>*Patients Reviewing Seizure Video Tapes CN# 7 CR</i> <i>*Patient Participation in Research, Investigation and Clinical Trials (CR)</i>	<i>*Operative and Other Invasive Procedures (CR)</i> <i>*Maintaining Confidentiality at CPM (CR)</i> <i>*Video Monitoring Unit CN# 8 CR</i> <i>*Video Tape Use CN# 1 CR</i> <i>*EEG Video Monitoring by Critical Care Monitoring Technician I # 24 CR</i> <i>*Cell Phones, Walkie-Talkies, and Wireless System Use # 228 CR</i>
*HIPAA *Patient privacy *Informed Consent (CR)		

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

<i>None</i>		
UAB Health System Committees		Date Reviewed
<i>None</i>		
Physician / Medical Committees		Date Reviewed
<i>None</i>		
Committees / Councils		Endorsement Date
<i>Kathleen Kauffman, Legal Council</i>		02/08/05
<i>Patricia Pritchett, Legal Council</i>		11/23/04
UAB Hospital		
<i>Deborah Grimes, JD, RN, Dir., JCAHO & Regulatory Affairs</i>		02/07/05
TKC		
<i>Marty Box, HR Director</i>		
<i>Penny Phillips, Director, Clinical and Systems Integration</i>		02/07/05
CEFH		
<i>Libby Bailey, CFO</i>		02/07/05
<i>Lynne Lanier, Asst Vice President, Patient Care Services</i>		02/08/05
<i>Karen Burleson, Asst Vice President, Human Resources/Risk Management</i>		02/09/05
<i>Louis Duhe', Asst Vice President, Ancillary & Support Services</i>		02/07/05
<i>Anne Banks, CEFH Public Relations</i>		02/14/05
Department(s)		Endorsement Date

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

<i>Scott Buchalter</i>	03/31/05	<i>Nancy Dunlap</i>	04/08/05	<i>Robert Morris</i>	03/14/05
Scott Buchalter, MD Chief of Staff UAB University Hospital	Date	Nancy Dunlap, MD Chief of Staff The Kirklin Clinic	Date	Robert Morris, MD Chief Staff Callahan Eye Foundation Hospital	Date

Tracking Record

Action				Reasons for Development/Change of Standard							Change in Practice		
Devel-oped	Refor-matted	Re-viewed	Revised	Re-quired Review	Rele-vance	Ethics	Legal	New Knowl-edge	QA/I	Risk	No	Yes	Comment/ Explanation of Impact
		X	X		X	X	X		X			X	<i>Allows patients to rescind their consent</i>
Supersedes:		Consent to Photograph, Videotape or Film , 10/21/02, 09/06/04											
File Name:		Consent to Photograph, Videotape, Audiotape or Film I# 510r2											
REVISIONS: Consistent with JCAHO Standards, this standard is to be reviewed at least every 3 years and/or as practice changes.													

Attachment A:



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

Attachment B:



**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 #: _(____)_____

Patient’s Address: _____

City, State, Zip: _____

Persons/organizations providing the information:

Persons/organizations receiving the information

Name: _____

Name: _____

Address: _____

Address: _____

City, State, Zip _____

City, State, Zip _____

Phone: _____

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 C:



**UAB HEALTH SYSTEM – Callahan Eye Foundation Hospital
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 #: (____) _____

Patient’s Address: _____

City, State, Zip: _____

Persons/organizations providing the information:

Persons/organizations receiving the information

Name: _____

Name: _____

Address: _____

Address: _____

City, State, Zip _____

City, State, Zip _____

Phone: _____

Phone: _____

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

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:



Hospital

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