



**Health System
INTERDISCIPLINARY STANDARD**

Title: <i>Consent to Photograph, Video, or Audio Record</i>		
Author: <i>David Gardner</i> 11/08/09 David Gardner, Data Security Specialist, Information Security	Author: _____ Date _____ HSIS	Distribution: Health System Wide
Endorsed: <i>Joan Hicks</i> 01/08/10 Joan Hicks, MS, RHIA, Chair, Information Security Privacy Comm.	Endorsed: _____ Date _____ NA	Pages 1 of 9
Approved: <i>Will Ferniany</i> 02/07/10 Will Ferniany, PhD, CEO, UAB Health System	Approved: _____ Date _____ NA	Written 02/07/01 Reviewed 11/08/09 Revised 11/08/09 Issued 02/01/10
CAMH Ref#: RI.01.01.01, RI.01.02.01, RI.01.03.01 (2009)		Discontinued:
Associated Diagnosis/-Cross-References (CR):	<i>Paper & Video Records, Release of (Health System) (CR)</i> <i>Copy of Seizure Monitoring Video for Patient (CR)</i> <i>Patients Reviewing Seizure Video Tapes (CR)</i> <i>Video Tape Use (CR)</i> <i>Video Monitoring Unit (CR)</i> <i>EEG Video Monitoring by Critical Care Monitoring Technician I # 24 (CR)</i> <i>Operative and Other Invasive Procedures (CR)</i>	<i>Maintaining Confidentiality at CPM (CR)</i> <i>Cell Phones, Walkie-Talkies, and Wireless System Use (Hospital) # 228 (CR)</i> <i>Patient Participation in Research, Investigation and Clinical Trials (CR)</i> <i>Authorized Media Recording in the Operating Room Suites (CR)</i> <i>Social Media Policy (CR)</i> <i>Use and Disclosure of Health Information for Marketing (CR)</i>

1. **PURPOSE:** To establish guidelines for photographing, video recording, or audio recording patients or employees of UAB Health System facilities and clinics.
2. **PHILOSOPHY:** It is our belief that any photographing, video recording, or audio recording, of patients or employees be done in a manner consistent with individual privacy rights.
3. **ASSOCIATED INFORMATION:**
 - 3.1. **Definitions:**
 - 3.1.1. **Subject** - An individual(s) being photographed, videoed or audio recorded. For the purposes of this standard, the individual may be a UABHS patient or employee.
 - 3.1.2. **Secure Location** - An area or place with restricted, and/or monitored physical access.
 - 3.1.3. **Recording device** – Any device that is capable of capturing and storing or transmitting still images, video or audio.
 - 3.2. **Background Information:** At times, it may be necessary to permit the photographing, video recording, or audio recording of the patients or staff members for various reasons, including teaching and marketing.
4. **STANDARDS:**
 - 4.1. When Permitted. Unless otherwise specified by UABHS policy, a subject may only be photographed, video recorded or audio recorded by a UABHS physician or other UABHS representative for the purpose of:
 - 4.1.1. Patient/staff identification
 - 4.1.2. Patient treatment
 - 4.1.3. Student/staff education
 - 4.1.4. Research
 - 4.1.5. Medical journal/publication
 - 4.1.6. Marketing by UAB Health System Marketing Communications
 - 4.2. **Consent.**
 - 4.2.1. Consent shall be obtained prior to photographing, video or recording a subject.
 - 4.2.2. The physician or other UABHS representative requesting/initiating the photographing, video recording, or audio recording of a subject shall obtain their prior consent.
 - 4.2.3. **General:**

- 4.2.3.1. For all photo, video ² and audio activities, other than those in support of research or those in support of marketing that involve a patient's health information, subject's consent shall be documented on the consent for the procedure being performed or on Consent to Photograph, Publish or Video Recording (**Attachment A**).
- 4.2.4. For Research:
- 4.2.4.1. Photographing, videorecording, or audio recording-patients for research must be done pursuant to a research protocol reviewed and approved by the UAB Institutional Review Board (IRB).
- 4.2.5. For Marketing/External Use and Involves Health Information:
- 4.2.5.1. Photographing, video recording, or audio recording patients by media (UAB or external) and other external entities that involves disclosure of health information shall be permitted only when the UAB Health System Authorization for Use or Disclosure of Information (**Attachment B**) or Callahan Eye Foundation Hospital Authorization for Use or Disclosure of Information (**Attachment C**) has been executed (as appropriate) by the patient and approval has been granted by Hospital administration or their designee.
- 4.3. **Executed consent forms** shall be stored by the department obtaining the recording in a secure location until all applicable recordings have been destroyed and are no longer in use by any UABHS entity.
- 4.4. The subject shall have the right to request cessation of recording.
- 4.5. A subject shall have the right to rescind consent for use of the photographs, video, or audio recordings 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.
- 4.6. Staff/faculty shall contact Media Relations whenever media requests access to faculty/staff/patients.
- 4.6.1. Media Relations or their designee shall be responsible for obtaining patient Authorization.
- 4.6.1.1. Patient's original Authorization forms shall be maintained in patient's medical record.
- 4.6.2. External media shall be accompanied by UAB Media Relations or designee.
- 4.6.3. UAB Media Relations or other administration representative shall obtain written agreements stating any limitations/restrictions on the use of recordings.
- 4.7. **Use of Recording Devices:**
- 4.7.1. All staff shall be vigilant for the presence of cameras/audio recorders within the institution.
- 4.7.1.1. Photographs, videos, or audio recordings 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.
- 4.7.1.2. Photography, video recording, or audio recording shall not occur during cardio-pulmonary resuscitation or other emergency or first-responder situations.
- 4.7.1.3. Cameras/audio recorders are not allowed on patient care units within the Center for Psychiatric Medicine.
- 4.7.1.4. Photography, video recording, or audio recording shall not occur during the course of vaginal or cesarean section deliveries.
- 4.7.1.4.1. Before and after the delivery of the infant, family members may record at the discretion of the caregivers and the physicians.
- 4.7.1.4.2. Photographs or video that exposes the patient's perineum, abdomen, or breast shall not be allowed.
- 4.7.1.5. Photography, video recording, or audio recording shall not occur during invasive procedures such as circumcisions or epidural placement.
- 4.7.1.6. Patient care must not be compromised in order to permit recording.
- 4.8. **Women's & Infants' Services.**

- 4.8.1. Photographing deceased ³ infants in Women's & Infants' Services shall be performed only after written consent has been obtained on the Women's & Infants' Services Bereavement Consent to Photograph (**Attachment D**), from parent or guardian.
- 4.8.1.1. 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.
- 4.8.1.2. Any film negatives, prints or electronic recordings not in possession of the family will be kept in conformance with applicable UABHS policy (e.g. HIPAA Privacy/Security and Records Retention standards).

4.9. **Law Enforcement.**

- 4.9.1. UAB Health System shall fully cooperate with law enforcement officers acting in the course of an official investigation to include photographing, video-recording, or audio recording.

5. **REFERENCES:** None

6. **SCOPE:** This standard applies to all areas in all entities of the UAB Health System.

7. **ATTACHMENTS:**

- Attachment A: Consent to Photograph, Video, or Audio Record
 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>		Date Reviewed
Physician / Medical Committees		
<i>None</i>		Endorsement Date
Committees / Councils		
<i>Kathleen Kauffman, Legal Council</i>		<i>01/29/10</i>
Department(s)		Endorsement 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, Audiotape or Film , 10/21/02, 09/06/04, 05/02/05											
File Name:		Consent to Photograph, Video, or Audio Record I# 510r3											
REVISIONS: Consistent with Joint Commission Standards, this standard is to be reviewed at least every 3 years and/or as practice changes.													



Patient or Employee
(Please indicate the status of the undersigned)

Consent to Photograph, Video, or Audio Record

The undersigned (Subject) does hereby agree and authorize UAB Health System Operating Entities including UAB University Hospital; UAB Highlands, University of Alabama Health Services Foundation (HSF), The Kirklin Clinic and other HSF-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 record, or audio record

_____ while under the care or employment of a UAB Health System facility or clinic for the purposes of patient/staff identification, patient treatment, student/staff education, research, medical journal/publication, marketing by UAB Health System Marketing Communications. Uses for recordings may include but are not limited to; news releases, website content, printed marketing brochures, training/educational videos, or other authorized forms of organizational communication (internal or public) without compensation of any kind. Each communication may also reveal the name and identity of the undersigned in a descriptive text or commentary associated with any recording(s).

The undersigned (Subject) and his or her heirs or next-of-kin do hereby relinquish all rights and privileges to all aforementioned negative(s), print(s), audio recording(s) 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 _____.

Subject or Legal Guardian

Print Name of Subject or Legal Guardian

Witness

UAB HEALTH SYSTEM

**UAB HEALTH SYSTEM – University 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),
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 re-disclosure 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 medical records:

Persons/organizations receiving medical records:

Name: _____

Name: _____

Address: _____

Address: _____

City, State, Zip _____

City, State, Zip _____

Phone: _____

Phone: _____

Specific description of information:

___ Face Sheet (from _____ to _____)

___ Discharge Summary (from _____ to _____)

___ History and Physical (from _____ to _____)

___ Pathology report (from _____ to _____)

___ Emergency room record (from _____ to _____)

___ Diagnostic procedure report(s) (from _____ to _____)

___ Lab report(s) (from _____ to _____)

___ Problem list (from _____ to _____)

___ Medication list (from _____ to _____)

___ X-ray report(s) (from _____ to _____)

___ Clinic notes (from _____ to _____)

___ Operative report(s) (from _____ to _____)

___ Consultation reports from (please supply physician’s name): (from _____ to _____)

___ Billing Records (from _____ to _____)

___ Radiology Films (from _____ to _____)

___ Other: (please describe & include dates of service):

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: _____

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)

___ 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: _____



Keyplate

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