CEDARS-SINAI®

CONSENT TO PHOTOGRAPH AND AUTHORIZATION FOR USE OR DISCLOSURE

Patient Name: _____

I hereby consent to be photographed while receiving treatment. The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images. I hereby authorize the use of the photograph(s) by, or disclosure of the photograph(s) to:

Cedars-Sinai Medical Group

Persons/Organizations authorized to receive the information

_____

Address (street, city, state, zip code)

PURPOSE

I hereby authorize the use or disclosure of the photograph(s) for the following uses or purposes (describe permitted uses, e.g., dissemination to physicians, health professionals, and members of the public for educational, treatment, research, scientific, public relations, marketing, news media, and charitable purposes):

I consent to be photographed and authorize the use or disclosure of such photograph(s) in order to assist scientific, treatment, educational, public relations, marketing, news media, and charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold the Medical Network, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

EXPIRATION

This Authorization expires *(insert date)*: _____

Upon expiration of this Authorization, this hospital will not permit further release of any photograph, but will not be able to call back any photographs or information already released.

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MY RIGHTS

I may request cessation of filming or recording at any time. I may rescind this Authorization up until a reasonable time before the photograph is used, but I must do so in writing and submit it to the following address:

CSMN, Health Information, 8501 Wilshire Blvd., Suite 244, Beverly Hills, CA 90211

I may inspect or obtain a copy of the photograph whose use or disclosure I am authorizing.

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[1]

I have a right to receive a copy of this Authorization.[2]

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

I understand that I will not receive any financial compensation.

If this box ☐ is checked, the medical Network will receive compensation for the use or disclosure of my photograph(s).[3]

SIGNATURE

	☐ AM ☐ PM
Date	Time
Patient Signature *or*	Legal Representative Signature
If signed by someone other than patient, indicate relationship	Print Name of Legal Representative

[1] If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment, or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[2] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 C.F.R. Section 164.508(c)(4).

[3] The Medical Network is to complete this section of the form.