Appendix B

Consent for Photography, Video, and Audio Release for Educational Purposes (PHI)

UC RIVERSIDE School of Medicine

Your Information		
Name		
Address		
City	**State**	**Zip**
Phone:	**Email:**	
☐ I am at least 18 years old.	☐ I am signing as the parent/guardian of:	

Patient Information	
Name: (If different from above)	**UCR Health Medical Record #:**
Physician Name:	**Department:**
Date(s) of treatment:	**Types of Health Info:**

Project Information
Name:
Type: ☐ Photo ☐ Videos ☐ Audio ☐ Promotional ☐ Educational ☐ Other _____
Purpose:

Purpose: By signing this document, you voluntarily grant UCR, the UCR School of Medicine, and/or UCR Health permission to take photographs, record audio and/or video, or other multimedia content that may contain health information about you during your healthcare treatment at the UCR Health ambulatory practice, UCR SOM sponsored clinic, or similar event, in accordance with SOM policy 950-02-006.

Your rights: You have the right to stop recording or photography at any time and may refuse to give permission without any penalty or loss of care or services. Your treatment, payment, enrollment, and eligibility for benefits do not depend on your granting permission.

- You will not be identified by name, but your face, voice, or other information that is unique to you may be recognized by others.
- The multimedia items will be stored on UCR SOM computers without your name. This form will be stored by the UCR School of Medicine.
- If you have any questions about your rights, please contact UCR Health Compliance via email at compliance@medsch.ucr.edu.

Expiration: Unless otherwise indicated, this authorization does not expire. If a request to revoke permission is received, it is understood that items that have been released into public may not be able to be recalled or removed **Initial** _____

I agree that UCR, the UCR School of Medicine and/or UCR Health own all rights to the multimedia items listed above. I waive all rights that I may have in the use of my likeness. The organizations will have the right to reproduce, distribute, sell, transmit, publish, exhibit, or otherwise use all the content listed above. I will not receive any payment for any use of them.

I have read this consent about the use of multimedia items that contain my health information. I understand the permissions I am giving. My questions have been answered to my satisfaction and I agree to what this form says. I will receive a copy of this form if requested.

Signature of Patient or Legal Representative	**Date**	**Relationship to Patient**
Signature of Witness or Interpreter	**Date**	**Phone number**
Signature of Person Obtaining Consent	**Date**	