Patient Authorization to Use or Disclose Photography/Video

Please read and complete the entire form in order for UW Medicine to process this request.

I, _____ authorize the following UW Medicine entities:

- ☐ Harborview Medical Center & Clinics
- ☐ Northwest Hospital & Medical Center & Clinics
- ☐ UW Medical Center & Clinics
- ☐ Valley Medical Center & Clinics
- ☐ Hall Health Primary Care Center
- ☐ UW Medicine Sports Medicine Clinic
- ☐ UW Medicine Neighborhood Clinics
- ☐ University of Washington Physicians

To take and or reproduce photographs/video of my face or body for:

_____

(State purpose of use or disclosure of information)

Description of photographs/video to be taken _____

_____

Person / Organization to receive the information: _____

_____

Information to be used or disclosed:

Photographs, video and/or electronic media.

Required Specific Release: ***(This must be completed)***

This authorization for release of records may include the release of the following specially protected information unless specifically excluded. Check appropriate boxes if you **DO NOT** want this information released:

- ☐ Reproductive care *(applicable to minors only)*
- ☐ Sexually transmitted diseases
- ☐ Mental Health
- ☐ Drug and alcohol treatment
- ☐ HIV/AIDS

Expiration of Authorization:

This authorization expires on _____ *(date)* **OR** when the following event occurs: _____ _____, *(State when UW Medicine is no longer authorized to disclose my information based on this authorization. If no date or event is listed above, this authorization is valid for three years from the date on which it is signed.)*

Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of one year from the date signed by you.

Minors: A minor patient's signature is required in order to release the following information **(1)** conditions relating to the minor's reproductive care **(2)** sexually transmitted diseases *(if age 14 and older)*, **(3)** alcohol and/or drug abuse and mental health conditions *(if age 13 and older)*.

By signing this page, I acknowledge that I have read and agreed to the terms on both sides of this form.

Signature *(Patient Or Person Authorized To Give Authorization)*	Date
If signed by person other than patient, print name, provide reason, relationship to patient, description of their authority	

PT.NO

NAME

DOB

Place EPIC Label Within Box

UW Medicine
Harborview Medical Center – Northwest Hospital & Medical Center
Valley Medical Center – UW Medical Center
University of Washington Physicians Seattle, Washington

AUTH TO USE/DISCLOSE PHOTOGRAPHY/VIDEO

U0324

UH0324 REV JUN 14

WHITE – MEDICAL RECORD
CANARY - PATIENT

Authorization to Use or Disclose Photography/Video

Potential for Redisclosure: Once disclosed, the law does not always require the recipient of your information to keep it confidential.

Revocation: This authorization may be revoked by submitting a request in writing to:

UW Medicine Compliance
Box 358049
Seattle, WA 98195

Note: A request to revoke this authorization will not affect any actions already taken based on the original authorization, or prevent UW Medicine from requiring the information in order to be paid for treatment that you receive.

I understand I have the right to:

- Inspect or to receive a copy of my protected health information
- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected health information

I also understand UW Medicine will not base treatment or payment decisions on receipt of this signed authorization, except in these cases (1) UW Medicine may condition research-related treatment on my signing or my providing an authorization for the use or disclosure of my information for such research; **or** (2) UW Medicine may condition the provision of healthcare that is just for the purpose of creating health information for disclosure to a third party on my signing or my providing an authorization for the disclosure of the health information to such third party. An example of this is when a non-UW employer contracts with UW Medicine to conduct TB testing for purposes of employee health screening.

For Office Use Only:

Type of Media	Site/Date
1. Photograph	
2. Video	
3. Voice	
4. Television	

Completed By:	Date:

PT.NO

NAME

Place EPIC Label Within Box

DOB

UW Medicine
Harborview Medical Center – Northwest Hospital & Medical Center
Valley Medical Center – UW Medical Center
University of Washington Physicians Seattle, Washington

AUTH TO USE/DISCLOSE PHOTOGRAPHY/VIDEO

U0324

UH0324 REV JUN 14 BACK