

## AUTHORIZATION TO USE OR DISCLOSE PHOTOGRAPHY/VIDEO TAPE

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
- University of Washington Medical Center & Clinics
- UW Medicine Neighborhood Clinics
- University of Washington Sports Medicine Clinic
- UW Medicine Eastside Specialty Center
- Hall Health Primary Care Center
- University of Washington Physicians

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

\_\_\_\_\_  
(State purpose of use or disclosure of information)

Description of photographs/video tape to be taken \_\_\_\_\_

Person / Organization to receive the information: \_\_\_\_\_

**Information to be used or disclosed:**

Photographs, moving pictures (video) and or closed circuit television pictures.

I further authorize such photographs/video tape may, at the discretion of the UW Medicine entity, be made a part of the medical record and may be made available for disclosure, as with my other medical records, upon receipt of a valid authorization or as required by law.

Expiration of Authorization:

This authorization expires on \_\_\_\_\_ (date) **OR** when the following event occurs: \_\_\_\_, (State when you want UW Medicine to stop disclosing information according to this authorization).

Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of 90 days from the date signed by you.

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

**UW Medicine**  
Harborview Medical Center – UW Medical Center  
University of Washington Physicians  
Seattle, Washington

**AUTH TO USE/DISCLOSE PHOTOGRAPHY**

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WHITE – MEDICAL RECORD  
CANARY - PATIENT

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**POTENTIAL FOR REDISCLOSURE:** Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information.

Revocation: I understand I may revoke this authorization by submitting the revocation in writing to UW Medicine Privacy Office, Box 356340, Seattle, WA 98195, at any time. Any revocation will not be effective to the extent that action has already been taken based on the original authorization or where UW Medicine requires the information in order to be paid for treatment provided to me.

I understand I have the following rights: a) To inspect or to receive a copy of my protected health information, b) To receive a copy of this signed authorization, and c) To refuse to sign this authorization.

I also understand UW Medicine will not condition treatment or payment based on receipt of this signed authorization, except (1) UW Medicine may condition research-related treatment on provision of an authorization for the use or disclosure of my information for such research; or (2) UW Medicine may condition health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party; for example, 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 PHOTOGRAPH	SITE/DATE
1. PHOTOGRAPH	
2. VIDEO	
3. CLOSED CIRCUIT TELEVISION	
COMPLETED BY:	DATE:

PT.NO	<b>UW Medicine</b> Harborview Medical Center – UW Medical Center University of Washington Physicians Seattle, Washington <b>AUTH TO USE/DISCLOSE PHOTOGRAPHY</b>  *U0324* *U0324*
NAME	
DOB	
UH0324 REV JAN 08	BACK

AUTHORIZATION - GRAY