Consent for Photographing and/or Recording of Patients (Non-clinical Care Purposes)

I hereby authorize the taking of photographs, movie film, videotape, audiotape, or the use of other recording media of:

Patient Name (print name): ____________________________

UConn Health Employee Responsible (print name): ____________________________

Purpose (please check ALL applicable boxes for any Internal/External purpose(s) below):

☐ Internal use in education, training or personnel performance activity only with UConn Health audiences. The term includes the use of patient photographs or recordings used for documentation of a trainee’s educational experience.
   ☐ The patient will be identified and/or would be able to recognize the data obtained as his/her own.

☐ External use in education or training provided to non-UConn Health audiences. For example, use in educational presentations to members of a state specialty or professional organization, or publication in professional journals or textbooks. Check ALL boxes applicable below:
   ☐ The patient will be identified and/or would be able to recognize the data obtained as his/her own.
   ☐ This use includes the sale of the data (this may include royalties).
   ☐ This sale may be further exchanged for payment by the entity receiving the data.
   ☐ This sale will NOT be further exchanged for payment by the entity receiving the data.

☐ UConn Health Publicity/Marketing or Media Use. For example, UConn Health may use on television or on radio, in newspapers, magazines, brochures, other promotional or patient education materials, exhibits or publications including UConn Health websites. Check ALL boxes applicable below:
   ☐ The patient will be identified and/or would be able to recognize the data obtained as his/her own.
   ☐ This use includes the sale of the data (this may include royalties).
   ☐ This sale may be further exchanged for payment by the entity receiving the data.
   ☐ This sale will NOT be further exchanged for payment by the entity receiving the data.

The purpose of this authorization is described in detail below:

__________________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________________
Consent for Photographing and/or Recording of Patients (Non-clinical Care Purposes)

Limited English Proficiency (LEP) – to obtain consent in any UConn Health location from this patient with LEP:
□ Live qualified interpreter was used   □ Language Line operator /interpreter (# ______) was used
Name of Interpreter: ________________________________________________________________

Telephone Consent Only: Consent via telephone requires the name of the person providing consent, their relationship to the patient and a witness other than the practitioner obtaining consent.

Person Providing Consent: ___________________________________________________________

Relationship to patient: □ Self; □ Parent; □ Guardian;
□ Authorized Representative (describe): ______________________________________________

UConn Health Employee Obtained by: (print name): ______________________________________

UConn Health Employee Obtained by: (signature): _______________________________________

Witness of other than practitioner obtaining consent: ____________________________________

Date: _______________    Time: □ AM_____________    □ PM_____________

I agree to the intended use of this authorization noted above. It has been explained to me that this authorization will expire only if I withdraw the authorization. I may do this at any time by written request to the responsible UConn Health employee noted above. Revocation of this authorization will only apply to the extent the data has not already been processed, utilized or otherwise circulated. Absent revocation, this authorization will remain valid for the purpose(s) specified. It has been explained to me that I do not have to sign this authorization to ensure my continued treatment.

Patient Signature or Authorized Representative** Date Time □ AM □ PM

Print Name

**Note, if signing on behalf of the patient, I have proven my identity and/or relationship to the patient as:
□ Parent; □ Guardian; □ Authorized Representative (describe): ____________________________

Obtained by: Signature of UConn Health Employee Date Time □ AM □ PM

Obtained by: Print Name of UConn Health Employee