Rady Children's Hospital San Diego

Rady Children's Hospital - San Diego
3020 Children's Way, MC #5049
San Diego, CA. 92123-4282

DT74010

PATIENT INFORMATION

Name: _____
MR#: _____ Finance: _____
DOB: _____
MD: _____

Authorization for Use, Disclosure or Publication of Photographs

Completion of this document authorizes the disclosure and/or use of Photographs, as set forth below, consistent with California and Federal law concerning the privacy of individually identifiable health information. Failure to provide all information requested may invalidate this Authorization.

PURPOSE, USE AND DISCLOSURE OF INFORMATION

Patient's Name _____ _____
Last First Middle Initial Birth Date

I, the undersigned, do hereby acknowledge that Rady Children's Hospital San Diego and its attending physicians have the right to photograph the above-named patient to assist clinical care or Hospital operations. I do hereby authorize **Rady *Children's Hospital San Diego*** and the attending physician, to photograph or permit other persons to photograph, the above-named patient(s) for non-treatment purposes including research, education, comparative purposes, and professional publication. The term "photograph" shall mean still photography in any format, as well as videotape and any other mechanical means of recording and reproducing images. Care will be exercised to assure that patient identifiers are removed from photographs used for educational, research and publication purposes. This authorization is hereby granted to:

Rady Children's Hospital San Diego
Name and Function of Person or Organization to which Disclosure is Made (Addresses available on request)

Date(s) of photograph: **During current Inpatient, Day Surgery or Emergency Care Center hospitalization or visit. Ambulatory encounter authorization will be obtained annually, following initial authorization.**

Requested Information shall be limited to the following: Photographic, Videotape, and other recorded images. I waive the right to compensation for the disclosure I have authorized and hold Rady Children's Hospital San Diego and the attending physicians and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this Authorization.

EXPIRATION

This Authorization expires 50 years: 07/01/2055 from the date signed or (insert date or event)

RESTRICTIONS

California law prohibits the Requestor from making further disclosures of my health information unless the Requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I understand that I have the following rights with respect to this Authorization:

- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to***: Rady Children's Hospital San Diego*, 3020 Children's Way, MC 5049 San Diego, CA 92123-4282.** My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.
- I have a right to receive a copy of this authorization upon my request. (Civil Code S.56.11)
- I understand my rights and I have decided that I *do not* want Photography taken for any purpose other than clinical care or healthcare operations. Sign below only if you wish to **"opt out"** of Photography for the purpose specified above:

_____
Signature of Legal Guardian – **for *OPT OUT* only**

PARENT / LEGAL GUARDIAN APPROVAL (sign below)

_____ _____ _____ _____
Signature Date Time Witness

_____ _____
Relationship to Patient Area Code and Phone Number