Patient Name

DOB:

MR #

Index to Consent – Treatment/Procedures

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

AUTHORIZATION FOR PHOTOGRAPH, AUDIO/ VIDEO OR OTHER MEDIA CAPTURE OF DEMOGRAPHIC AND/OR HEALTHCARE INFORMATION (For the Purposes of Clinical Care, Education and/or Quality Assurance)

Date: _____

I allow the University of Wisconsin Hospital and Clinics Authority (UWHCA) faculty/staff to record demographic and/or healthcare information for the purposes of clinical care, education, and/or quality assurance. They may use media or video capture of _____ (myself/name of patient). I have been told that those who produce this media are bound by the confidentiality polices of UW Health. I have checked below the types of media I allow and the reasons they may be used:

Media: ☐ All media capture (photo, video/audio)

☐ Other:_____

Check Only One:

☐ **I Allow** for photo / video / other captured media to be taken for **use in my medical record only.**

OR

☐ **I Allow for use in my medical record and also for education.** I consent to photos / video / other captured media to be shown within the UW Health System for education and for use in the medical record. While the images shown are anonymous, I understand that it may not be possible to hide my identity.

If you allow for use in education, please select yes or no below:

☐ **Yes** ☐ **No I allow for use in publication (electronic and medical publication for teaching).** I consent for this media capture to be used in medical publications. This includes medical journals, textbooks, educational seminars, and electronic publication (internet-based publications). I understand that the images(s) may be seen by members of the public, along with doctors, medical researchers and scientists who frequently use these publications in their professional education. While the images published are anonymous, I understand that it may not be possible to hide my identity.

It is understood that in any such publication or use (other than my personal health record), I shall not be identified by name. It is also understood that I will not be notified of these publications or paid for any publication.

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By signing, I confirm that this consent has been explained to me in terms which I understand. I understand that I do not have to sign this form and may refuse to do so. Unless allowed by applicable law, UW Health Care Providers may not refuse to provide me /named patient treatment or other health care services if I refuse to sign this form. I understand that I have the right to revoke this consent, in writing, at any time. My written withdrawal is effective, except to the extent that the person(s) and or organization(s) listed on this form have taken action in reliance on this consent. My withdrawal is considered on a case-by-case basis. I must submit my request to revoke this consent in writing to UWHC's Patient Relations Department. For more information, I may call (608) 263-8009.

AUTHORIZING SIGNATURES:

Signature of Patient/Representative _____ Date: _____ Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

Patient is: □ Minor □ Incompetent / Incapacitated
Legal Authority: □ Legal Guardian □ Parent of Minor
□ Health Care Agent □ Other _____

Physician Signature: _____ Print Physician Name: _____

Date: _____ Time: _____ Pager# _____

_____ _____
Interpreter or Reader Signature (if applicable) Witness Signature*

_____ _____
Print Interpreter or Reader Name Print Witness Name

_____ _____
Date Time Date Time

* Only required if patient signature not obtained by physician or when telephone consent obtained.