I. Policy Summary:
The purpose of this policy is to specify the conditions and requirements for interviewing, photographing, videotaping or filming of patients and staff in the UCR Health facilities, whether it is done internally by UCR Health staff or faculty for treatment, educational or research purposes, or by external parties for news coverage or for documentary or commercial purposes.

II. Definitions:
Refer to Standard Definition Guide Document.

III. Policy:
A. It is the policy of UCR Health that no interviewing, photographing, videotaping or filming of patients, staff, faculty or students is allowed unless it meets the requirements set forth in this Policy, which is intended to protect the confidentiality and privacy of patients and staff while allowing photography and filming under appropriate circumstances.
   1. Photography will not be allowed if it interferes with patient care or UCR Health functions.
   2. The patient has the right to revoke his or her consent for interviewing, photographing, videotaping, or filming at any time.
   3. If the photograph is used for patient care purposes, the photograph must be placed in the patient’s legal health record, and deleted immediately from the camera.
   4. Images used for other than patient care purposes may be recorded on a digital camera with the images immediately downloaded to a UCR Health secure network server.
   5. Patient use of any electronic recording device is prohibited without the express consent of the staff.

IV. Responsibilities: N/A

V. Procedures:
A. All Staff And Registration Staff
   1. The patient or his/her legal representative must give written consent for photography of the patient, except for Medical Photography. Medical photography is covered in the University’s Terms and Conditions form given to all patients at first encounter in the ambulatory practices, and a separate consent form is not required.
   2. If the images are intended to be used for educational purposes, the Consent Form
should specify the purpose for the photography and inform the patient that he or she has the right to revoke such consent for use of the photographs until a reasonable time before the photograph is used, except to the extent that UCR Health or others have relied on it. Please refer to Appendix A for the UCR Health Consent for Photography and Use of Protected Health Information for Educational and Teaching Purposes.

3. If the images are intended to be used for media, community relations and other similar purposes, the patient must sign an authorization form for use of the images. Please refer to Appendix B, Authorization to Use and Disclose Protected Health Information (PHI) For Media/Marketing and Other Related Purposes.

4. Before a recording of a patient can be made, anyone involved in the photography who is not already bound by a UCR Health Confidentiality Agreement may be asked to sign a confidentiality statement to protect the patient’s identity and any confidential information, which is not subject to the Authorization.

5. Written consent from the patient is required in advance of the photography, except in the limited circumstances if photography is performed by UCR Health faculty for research or teaching purposes, and it is not possible to obtain consent in advance.
   a. The patient or the patient’s personal representative shall be informed of photographing, filming or recording that occurred prior to obtaining the signed Terms and Conditions form.
   b. In these limited circumstances when consent cannot be obtained in advance, the film or other media used for the photography, must remain in the possession of UCR Health and not used for any purpose, until appropriate consent has been obtained.
   c. If the consent is not obtained, then the patient’s images must be removed from the photograph or film, or the photograph or film must be destroyed.

6. Photography for research purposes must be included in the IRB approval for the protocol, and appropriate patient consent obtained as permitted by the IRB. The applicable HIPAA Research Authorization must also cover the use and disclosure of photograph(s). The photographs must stay with the protocol binder or medical record if for clinical care. Any additional uses of the materials may require additional authorization from the research subject.

7. Research Subject Consent may not be required if the photography is used for research or teaching purposes and the patient is not identifiable. Photographs and images collected prospectively for a research project may require a waiver of authorization or consent from the IRB to collect and use the images. Research protocols requiring photography with patient identifiers as part of the study would have a patient consent and HIPAA Research Authorization for the use of PHI. However, the IRB approval for the protocol must still include the photography in the approved protocol.

8. If the protocol requires the de-identification of the photographic images, the images must be de-identified by:
   a. Masking of identifiable features so that the image is not recognizable; or
   b. Removal of all labels containing patient name, medical record number, date of service, account number and any other unique identifiers. Refer to Appendix C which lists the 18 identifiers that must be removed in order to de-identify patient information.

9. Photography is prohibited if in the opinion of the patient’s attending physician, the photography will jeopardize the patient’s condition or interfere with the care of the patient, or if the patient requests that the filming stop. The patient has the right at
any time to request that the filming stop.

10. Photography by outside organizations requires oversight by the UCR School of Medicine Compliance and Privacy Office and School of Medicine Strategic Initiatives Office. Anyone who photographs or videotapes for commercial purposes who is not a UCR Health employee and not a member of the news media must sign an appropriate Visitor and Vendors Confidentiality Statement (Appendix D) to protect the patient’s identity and confidential information and abide by relevant UCR campus policies for commercial filming. News crews must wear proper media credentials.

11. Such Photography must comply with UCR Health’s Policy on “Permissible Disclosures of Protected Health Information (“PHI”) to the Media and the Public” to protect patient privacy. Appropriate notice must be given if filming occurs in UCR Health facilities, such as posting signs in public areas. News crews must wear proper media credentials.

12. If the Photography includes third parties (other than the patient) such as staff, visitors, students or trainees, their written or verbal consent must be obtained, except in public areas. The third party may revoke their consent at any time. If such consent is not possible, the Compliance and Privacy Director should be contacted. If it is determined that consent was not obtained, then UCR Health may retain the film, negatives, or other electronic media used for the Photography. When Photographs are utilized for demonstration of ‘before and after’ results, the Consent to Photograph and Authorization for Use and Disclosure (Appendix E) must be completed and signed by the patient. The specifics of the areas photographed and a clear statement of how the photographs will be utilized must be included in this authorization.

B. Medical Records

1. Patient photographs are subject to the laws governing confidentiality of medical information. Original Authorization and Consent Form(s) signed by the patient authorizing the photography should be placed in the patient’s medical record. A copy of the Consent Form should be maintained by the Department requesting the Photographs and a copy should be given to the patient.

2. For Medical Photography or abuse reporting, the photographs including any negatives should be maintained in the Medical Record.

3. UCR Health workforce members may not post, distribute, send or otherwise disclose pictures of patients through email, internet postings or text or picture messaging via cell phones or other public forum. Violations will subject workforce members to discipline up to and including termination.

C. All Staff

1. All photographs taken in any format must be secured according to the UCR Health policy Use of Protected Health Information on Portable Computing Devices. For medical photographs taken on digital cameras, the electronic image on the camera must be deleted after the photograph is incorporated into the patient medical record.

2. For photographs taken for educational and research purposes, the information and images can only be used or disclosed as authorized by the patient in the applicable authorization and/or consent form and as per the IRB protocol approval. The Attending Physician and/or Principal Investigator are responsible for storage and safeguarding of the patient’s photographic information until no longer needed or until
the patient’s authorization expires.

D. Abuse and Reporting Requirements

1. Physicians, Nurses
   a. If the photographs will be used for purposes of diagnosing or reporting possible abuse, including child abuse, consent is not required.

2. Physician Risk Management
   a. If the patient’s ability to give consent is impaired, and if the physician or law enforcement officer determines that photographs are necessary to preserve evidence of the patient’s physical condition, the physician may authorize the photographs. The Compliance and Privacy Director should be contacted as appropriate in these situations for further guidance.
   b. The physician should document this determination in a dated and timed note in the patient’s medical record. If a law enforcement officer requested the photographs, the officer's name and badge number shall be documented in the medical record.

VI. Forms/Attachments:

Appendix A: Consent for Photography for Media and/or Fundraising Purposes
Appendix B: Authorization to Use and Disclose Protected Health Information (PHI) For Media/Marketing and Other Related Purpose
Appendix C: 18 Identifiers
Appendix D: Confidentiality Statement for Non-Workforce Members
Appendix E: Consent for Before-and-After Photograph and Authorization for Use and Disclosure

VII. Related Information: N/A

VIII. Revision History: 1/2016 - 3/2016

Approval(s):

Compliance Committee (04/26/2016)
Appendix A

CONSENT FOR PHOTOGRAPHY AND AUTHORIZATION FOR RELEASE OF MULTI-MEDIA FOR EDUCATIONAL PURPOSES

UCR Health Medical Record #
Patient Name:

Faculty Member/Attending Physician Name ______________________________
Department ____________________
Telephone Number ____________________

Purpose: We ask your permission to take photographs, record films and/or create multi-media items that contain health information about you. The multimedia items will be taken or made during the course of a healthcare treatment at the UCR Health ambulatory practice. We want to share this health information about you with other individuals and entities either inside or outside UCR Health for educational purposes, so that other health sciences professionals and students can learn about your condition or disease. This will benefit other patients.

Confidentiality: You will not be identified by your name. Other people may recognize your face or voice or other information that is unique to you. The multimedia items will be edited and stored on a computer without your name.

Notice: UCR Health and many other organizations and individuals such as doctors, nurses, dentists, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights: You have the right to have the filming or photography stop at any time, and have the right to revoke your consent at any time, prior to publication. Upon publication, it is not possible to rescind your consent. Giving permission for us to use these items is voluntary. You may refuse to give permission without any penalty or loss of care or services. Your treatment, payment, enrollment and eligibility for benefits do not depend on your signing this permission form. If you have any questions about your rights, contact the UCR Health Compliance and Privacy Office, 900 University Avenue, Riverside, California 92521.

Expiration: Unless you revoke your permission earlier, this authorization expires on ____________________. If no date is indicated, this authorization will expire fifty years after the date of your signing this form.

I give permission for these multimedia items to be taken or made and used:

☐ Photographs: ______________________________________________________
☐ Videos/films: ______________________________________________________
☐ Audiotapes/audioclips: _____________________________________________
☐ Radiographs and other medical images: _______________________________
☐ Other multimedia items: _______________________________________

Health information regarding my medical condition or treatment to be released (please specify the health information you authorize for release):
- Type(s) of health information: ________________________________
- Date(s) of treatment: _______________________________________

I give permission to UCR Health to use these multimedia items for these educational purpose(s):
- Training of health sciences professionals at UC Riverside, including students, faculty and others in the UC Riverside School of Medicine (for example classroom lectures, faculty presentations, student projects, laboratory manuals, and online curriculum materials).
- Use in professional publications, presentations, textbooks and at professional conferences.
- Storage in repositories and databases of teaching materials for the health sciences.

Revoking Your Permission: You may change your mind and withdraw your permission for use of the photographs, films or other materials at any time, without any penalty or loss of care or services. To revoke your permission, write a letter, sign it and deliver it to the UCR Health, Compliance and Privacy Office, 900 University Avenue, Riverside, California 92521.

The revocation letter will take effect when UCR Health receives it, except to the extent that UCR Health or others have already relied on it. If the multimedia items have been shared, it may not be possible to recall them.

I agree that UCR Health will own any and all rights in the multimedia items listed above. I waive any and all right that I may have in the use of my likeness or photographs. UCR Health will have the right to reproduce, distribute, sell, transmit, publish, exhibit, or otherwise use the multimedia items listed above. I will not receive any payment for any use of them.

I have read this consent about the use of multimedia items that contain my health information. I understand the permissions I am giving. My questions have been answered to my satisfaction and I agree to what this form says. I will get a copy of this consent.

________________________________________________________________________________________
Signature of Patient or Legal Representative Date

________________________________________________________________________________________
Signature of Witness of Interpreter Date

________________________________________________________________________________________
Signature of Person Obtaining Consent Date
Appendix B

Authorization to Use and Disclose Protected Health Information (PHI) For Media/Marketing and Other Related Purposes

I authorize UCR Health to release my protected health information to (specify the name(s), the following news organizations or other outlets:

By signing this Authorization, I understand and agree that:

1. UCR Health may use my protected health information for the following purposes:
   - Marketing (e.g. brochures, billboards, other advertisements about UCR Health Services)
   - News Media/Documentaries (e.g. TV, newspapers, magazines)
   - A media or entertainment consultant to obtain understanding of healthcare activities
   - Other (specify) ____________________________________________

2. The following types of protected health information may be used or disclosed by UCR Health:
   - All of the following
     - Name
     - Street Address, City and State
     - Phone Number
     - E-mail Address
     - Date of Birth/Age
     - Photograph/Video Image
     - Personal Story
     - Diagnosis/Method of Treatment
     - Date(s) of Treatment
     - Other

3. Once UCR Health disclosed my health information to the general public, including members of the news media or others who may widely distribute this information, UCR Health cannot guarantee that these recipients will not re-disclose my health information to others. Recipients of my protected health information may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

4. I may refuse to sign or may revoke (at any time) this Authorization for any reason and that refusal or revocation will not affect the commencement, continuation or quality of my treatment at UCR Health.

5. This Authorization will remain in effect until the term of this Authorization (as set forth below) expires or I provide a written notice of revocation to UCR Health Information Management Office at the address listed in Paragraph 6 below. The revocation will be effective immediately upon receipt of my written notice, except that the revocation will not have any effect on any action taken by UCR Health in reliance on this Authorization before it
received my written notice of revocation.

6. If I have questions regarding this Authorization, or the use of my protected health information, or if I desire to revoke this authorization, I may contact UCR Health, Health Information Management Office: By telephone: (951) 827-3257. By mail: UCR Health, Compliance and Privacy Office, 900 University Avenue, Riverside, California 92521.

TERM:
This Authorization will remain in effect:
- From the date of this Authorization until the termination of the following fund-raising or marketing campaign:
  - Until (date) _______________
- Other: ________________________________

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize UCR Health to use or disclose my health information in the manner described below.

Signature of Patient ___________________________ Date __________________
Print Name (Last) ___________________ (First) ___________________ (Middle) __________
Home Address ________________________________

Home Telephone ________________________ Date of Birth _______/_____/____________

If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Personal Representative _________________________ Date _________
Printed Name of Personal Representative ________________________________
Description of Authority _______________________________________
(Relationship to patient)
Appendix C

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<thead>
<tr>
<th>EXCLUDES</th>
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</thead>
<tbody>
<tr>
<td>2. Street Address, City, State, Zip code *</td>
<td>8. Medical record numbers</td>
<td>14. Web universal resource locator (URL)</td>
</tr>
<tr>
<td>3. All Dates (including dates of treatment): Age &lt;90: All elements of</td>
<td>9. Health plan beneficiary numbers</td>
<td>15. Internet protocol (IP) address number</td>
</tr>
<tr>
<td>dates, except year); Age &gt;89: All elements of dates including year</td>
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<tr>
<td>4. Telephone numbers</td>
<td>10. Account numbers</td>
<td>16. Biometric identifiers, including finger or voice prints</td>
</tr>
<tr>
<td>5. Fax numbers</td>
<td>11. Certificate license numbers</td>
<td>17. Full face photographic images and any comparable images</td>
</tr>
<tr>
<td>6. Electronic mail addresses</td>
<td>12. Vehicle identifiers and license</td>
<td>18. Any other unique identifying number, characteristic or code</td>
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<td>numbers</td>
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* Please note that the term 'Zip code' refers to the ZIP code in the context of addresses.
CONFIDENTIALITY STATEMENT
For Non-Workforce Members

The federal Health Insurance Portability and Accountability Act ("HIPAA") and its regulations, the California Confidentiality of Medical Information Act and other federal and state laws and regulations were established to protect the confidentiality of medical and personal information, and provide, generally, that patient information may not be disclosed except as permitted or required by law or unless authorized by the patient. In certain circumstances, HIPAA allows the disclosure of limited patient information in order to carry out treatment, education, research, public health, or health care operations activities without obtaining the patient or subject’s authorization.

Confidential Patient Information includes: Any individually identifiable information in possession of or derived from a provider of health care regarding a patient’s medical history, mental or physical condition or treatment, as well as the patients’ and/or their family members’ records, test results, conversations, research records and financial information. (Note this information is defined in the Privacy Rule as “protected health information.”) Examples include but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Computerized patient data;
- Visual observation of patients receive medical care or accessing services; and
- Verbal information provided by or about a patient.

I understand and agree that this document establishes a Confidentiality Agreement between me ______________________ [insert name of Individual] a representative of ______________________ [insert name of employer] and UC Riverside and sets forth the understanding regarding the protection of any confidential information that Individual may have access to while performing services at UC Riverside with the following purpose:_________________________________________________________

1. I understand that I will be granted access to, or otherwise become acquainted with, the following information (“Information”) relating to UC Riverside Health patients:
   - Clinical/medical information
   - Insurance and Billing information
   - Scheduling information
   - Visual observation of patients receiving medical care or accessing services
   - Other (describe)______________________________________________

   It is understood and agreed that except as required by law, I will use and hold all Information in strict trust and confidence, and will use such information only for the purposes contemplated herein, and not for any other purpose.

2. I acknowledge that it is my responsibility to respect the privacy and confidentiality of Information received from UC Riverside I will not access, use or disclose patient or other confidential information unless I am authorized or permitted to do so by law or as authorized by the patient. I further understand that I am required to immediately report any information about authorized access use or disclosure of confidential patient information to UC Riverside.
3. I agree to not disclose the Information to any other individuals.

4. Neither the release of any information hereunder or the act of disclosure shall constitute a grant of any license under a trademark, patent, or copyright or application of the same.

5. I understand and acknowledge that, should I breach any provision of this Confidentiality Statement, I may be subject to civil or criminal liability.

_________________________  __________________________
(Signature)                 (Date)

__________________________________
(Print Name)
Appendix E

CONSENT FOR BEFORE-AND-AFTER PHOTOGRAPHS AND AUTHORIZATION FOR USE AND DISCLOSURE

Patient Name:

CONSENT TO PHOTOGRAPH; AUTHORIZATION FOR USE AND DISCLOSURE

I hereby consent to be photographed while receiving treatment at UCR Health. The term “photograph” includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I hereby authorize the use of photographs by UCR Health for the purpose of demonstrating before-and-after procedure comparisons. I consent to my photographs being viewed by third parties including other patients and their family members, at the discretion of UCR Health faculty.

SPECIFIC AREA TO BE PHOTOGRAPHED / VIEWED

I consent to be photographed and authorize the use or disclosure of such photograph(s) in order to assist scientific, treatment, educational, public relations, marketing, news media, and charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold UCR Health, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

EXPIRATION

This Authorization expires 20 years from date of signature

Upon expiration of this Authorization, UCR Health will not permit further release of any photograph, but will not be able to call back any photographs or information already released.
I may request cessation of filming or recording at any time.

I may rescind this Authorization up until a reasonable time before the photograph is used, but I must do so in writing and submit it to:

University of California, Riverside
School of Medicine Compliance Office
900 University Avenue
Riverside, California 92521

I may inspect or obtain a copy of the photograph whose use or disclosure I am authorizing.

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I have a right to receive a copy of this Authorization.

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

I understand that I will not receive any financial compensation.

Date: ____________________________  Time: ____________________________ AM / PM

Signature: ____________________________

(patient/representative/spouse/financially responsible party)

If signed by someone other than patient, indicate relationship:

______________________________

Print name: ____________________________

(patient/representative/spouse/financially responsible party)

If this form is verbally translated please complete the following:

Translation to what language: ____________________________

Name of translator or translation service: ____________________________

Signature or ID# ____________________________