AUTHORIZATION TO USE OR DISCLOSE PHOTOGRAPHY/VIDEO TAPE

PLEASE READ AND COMPLETE THE ENTIRE FORM IN ORDER FOR UW SCHOOL OF DENTISTRY TO PROCESS THIS REQUEST

I, _______________________________________authorize UW School of Dentistry 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 that such photographs/video tape may, at the discretion of UW School of Dentistry, 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 School of Dentistry to stop disclosing information according to this authorization). If this authorization is for the purpose of disclosing information, other than for payment purposes, to an employer or financial institution, than the authorization will be effective for 90 days or less from the date signed as specified 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	

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 that I may revoke this authorization by submitting the revocation in writing to the UW School of Dentistry Compliance Director, Box 356365, 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 School of Dentistry requires the information in order to be paid for treatment provided to me.

I understand that 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 that UW School of Dentistry will not condition treatment or payment based on receipt of this signed authorization, except (1) UW School of Dentistry may condition research-related treatment on provision of an authorization for the use or disclosure of my information for such research; **or** (2) UW School of Dentistry 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 School of Dentistry 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: