Texas Health Surgery Center Bedford		Policy No. PR-11
Prepared by: LB	Approved by: MEC	Title – Ethics, Rights & Responsibilities PR-Photographing and/or Videotaping of Patients
Origin Date: 5/17		
Date reviewed or revised:	Page 1 of 6	

Purpose:
To ensure the privacy and confidentiality of patients

Policy:
It is the policy of Texas Health Surgery Center Bedford to obtain patient consent prior to any type of photography, videotaping, or other imaging. Patient photography is routinely used to document patient care. Videotaping may be used for marketing purposes.

Procedure:
1. Prior to taking any type of photography of patients, permission will be obtained from the patient/legal guardian and a consent form signed. When recordings or films are made for external purposes that will be heard or seen by the public (for example, commercial filming, television programs, marketing), there is documentation of a specific, separate consent that includes circumstances of the use of the recording or film.
2. The facility is responsible for obtaining consent from the patient/legal guardian.
3. The consent is effective only during the patient's treatment at Texas Health Surgery Center Bedford.
4. Photos should not include other patients/family members.

Documentation of Patient Care:
Needs that may require photographic documentation include but are not limited to, pressure sores, wounds, incisions, changes in skin integrity.
1. The facility is responsible for obtaining consent from the patient/legal guardian.
2. The photograph(s) will be labeled with the patient's name and date of photos.
3. The photos will be attached to the medical record when appropriate.
4. If unable to give consent before recording or filming occurs:
   a Filming or recording may occur, provided it is within the established policy of the organization and the policy is established through an appropriate ethical mechanism (for example, an ethics committee) that includes community input (standard).
   b The recording or film remains in the organization's possession and is not used for any purpose until and unless consent is obtained.
   c If consent for use cannot be obtained, the recording or film is either destroyed or the non-consenting patient must be removed from the recording or film.
5. Patients have the right to request cessation of recording or filming at any time.
6. Patients have the right to rescind consent for use up until a reasonable time before the recording or film is used.

Documentation of Abuse or Neglect:
Photographs used for documentation of abuse and/or neglect may be submitted to an investigating agency. Every attempt will be made to secure consent before photographs are taken; however, failure to obtain consent will not preclude the reporting of such incidents. Such photographs taken should not be used for any other purpose (such as teaching) without patient consent.

Research:
Photographs taken as part of a research protocol should be approved by an institutional review board or other appropriate committee. Consent for such photography should be incorporated into the consent form the patient signs to participate in the research protocol.

Medical Education, Teaching, or Publicity:
Written consent should be obtained before photographing patients for medical education, staff teaching, or publicity purposes. The patient or his/her legal representative should sign and date the consent form. Anyone other than the patient who has the legal authority to sign should indicate his/her relationship to the patient. The signature should be witnessed, and the witness should sign in the space provided on the form. The signed consent form should be filed with the patient's medical record or in another secure place.
A new consent form should be signed for each new series of photographs taken by individuals other than those named in prior consents. The consent given for photography remains valid unless and until the patient or his/her legal representative withdraws or restricts the authorization.

Law Enforcement:
When representatives from law enforcement agencies ask to photograph a patient, permission may be given if (1) the patient's physician does not feel it would be detrimental to the patient; and (2) the patient or his/her legal representative signs a written consent form agreeing to the photography.

Family:
Consent is not needed for photography done by the patient's family members or friends.

Maintenance:
All photographs taken will be documented in the medical record and will become a permanent part of the medical record. Each photograph shall be identified with the patient's name, identification number, and the date it was taken.

Disclosure:
Photographs will not be released to outside requesters without specific written authorization from the patient or his/her legal representative.

If patients want the photographs for his/her own use, a copy of the photographs may be provided to the patient. The cost of reproducing the photos will be maintained by the facility.

References:

1. The Joint Commission, Standards for Ambulatory Surgical Centers 2017: Ethics, Rights, and Responsibilities

CONSENT FOR PATIENT PHOTOGRAPHY and/or VIDEOGRAPHY

I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I consent to this. I hereby give my consent to have photograph/photographs, videotape, digital or other images taken of my _____.
(Name of body part(s)

I understand that **Texas Health Surgery Center Bedford** will retain ownership rights to these photographs, videotapes, digital or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law. Images that identify me will be released and/or used outside the facility only upon written authorization from me or my legal representative.

I consent to have my images used for general purposes of training and education, or for promotional activities, or for information that is deemed newsworthy. My images will only contain the structure(s) identified above. I also have the right to rescind the consent at any time prior to the use of my images.

_____

Signature or Patient or Legal Representative Date

_____

Signature of Witness Date

(If phone consent is obtained second witness is required.)

_____

Signature of second Witness Date

RELEASE, WAIVER OF LIABILITY AND INDEMNITY AGREEMENT

SURGICAL CARE AFFILIATES

In consideration of _____ being permitted to film, tape or otherwise record the premises, property, and/or the facilities of _____, Inc. d/b/a _____ located at _____, their agents, employees, successors and assigns, (individually and collectively referred to as the "Undersigned"), acknowledge and agree that the Undersigned:

1. Hereby release, waive and discharge SURGICAL CARE AFFILIATES, its officers, directors, shareholders, partners, employees, contractors, agents, affiliates, successors, and assigns, (all herein referred to as "Releasees") from all liability to the Undersigned for any and all loss, damage or expense, and any claim, demand or suit therefore on account of injury or damage to the person, employees, or property of the Undersigned, whether caused by the negligence of Releasees or otherwise;

2. Hereby agree to indemnify, save and hold harmless the Releasees, and each of them, for any loss, liability, damage, cost or expense they or any other person or entity may incur during, or as a result of the filming, taping, or recording done by_____, and any and all preparation , set-up or wrap-up thereof;

3. Hereby agree:
   a. that the filming, taping or recording of the surgical case will not interfere with any patients' procedure, treatment or visit at SURGICAL CARE AFFILIATES;
   b. that the Undersigned will not film, tape or record other patients of SURGICAL CARE AFFILIATES, either by permission or through accident or inadvertence; and
   c. that the Undersigned will not disrupt, interfere, or otherwise inconvenience the normal business operations and working atmosphere of SURGICAL CARE AFFILIATES during the filming, taping, or recording of the procedure.

4. Hereby agree that no oral or written representations, statements or inducements concerning the matters in this Agreement have been made to the Undersigned, and agrees that this Agreement supersedes any and all prior agreements between the Undersigned and the Releasees concerning the matters contained herein, including the Location Agreement between the two parties.

5. Hereby agree that any film, video, tape or other recording of the facility, or of any and all preparation, setup, or wrap-up thereof is to be solely used in the manner described to _____ the SURGICAL CARE AFFILIATES employee in charge, and is not to be shown, used, duplicated for use, or referred to for any other purpose whatsoever by any entity or person without the prior written approval of an officer of SURGICAL CARE AFFILIATES.

The Undersigned has read, understood and voluntarily signs this Release, Waiver of Liability and Indemnity Agreement.

Date: _____ _____

It's Authorized Representative

Address: _____

SCA

Surgical Care Affiliates

RELEASE FORM

The undersigned has agreed to be filmed, videotaped, photographed, or otherwise recorded in _____ _____ (NAME OF SCA FACILITY). SCA anticipates that the resulting film, videotape, photograph, audio recording, or other like materials will be broadcast to the general public on television or otherwise disseminated to the public through other forms of media. In consideration for these materials to be produced in _____ (NAME OF FACILITY), I agree to the following:

I, _____ (PRINT NAME), agree to have my surgical procedure,

_____ (NAME OF SURGICAL PROCEDURE) and other related health care services

performed by _____ (NAME of PHYSICIAN), filmed, videotaped, photographed or

otherwise recorded on _____ (MONTH, DAY, and YEAR).

I relinquish and transfer to **SCA**, and _____ (INSERT NAME OF PHOTOGRAPHER, VIDEOGRAPHER, physician, etc.), all necessary legal title, property rights, copyright interest, and rights of reproduction, distribution, derivative works, public performance and display, in the information, photographs, video, sound recording and other items or materials gathered or received in the course of my treatment on the date above for the purposes described herein.

I authorize SCA, and its assigns, to publish, edit, preserve, display, copyright, use and reproduce my name and likeness, and any photographs, video, sound or other items, materials or information gathered from me, in any manner they deem appropriate.

I waive any payment or compensation for my interview, time, photographs, video, sound or other items, and any use of the materials or information obtained from me.

The rights I have granted to SCA in this document shall be irrevocable and shall survive my death. I reserve the right to grant similar, non-exclusive rights to other persons.

The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Regulation.

I realize it is my right to revoke authorization, in writing, up to the time my information has been released.

I understand that SCA may not condition treatment on whether or not I sign this authorization form.

_____
Patient

_____ _____
Patient Signature Witness Signature

_____ _____
Print Patient Name & Telephone Number Witness Printed Name

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient name: _____ ID Number: _____

Persons/organizations providing the information: Persons/organizations receiving the information:

_____ _____
_____ _____
_____ _____
_____ _____

Specific description of information (including date(s)): _____
_____
_____
_____
_____

Section B: Must be completed only if SCA is requesting the information for its own uses and disclosures.

1. SCA must complete the following:
   a. What is the purpose of the use or disclosure? _____
   b. Will SCA receive payment, directly or indirectly, in exchange for using or disclosing the health information described above? Yes ___ No___
2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.
   Initials: ____
   b. I understand that I may inspect or copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: ____

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _ _/_ _/_ _ _ _ (DD/MM/YR) Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any actions taken before receiving the revocation. Initials: _____

_____ _____

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing)

Printed name of patient's representative: _____

Relationship to the patient: _____