Children's Hospital and Health System, Inc.
Administrative Policy and Procedure

SUBJECT: Privacy: Photographing - Videotaping and Other Imaging of Patients

POLICY

It is the Policy of Children's Hospital and Health System (CHHS) to protect its patients, within reasonable limits, from invasion of privacy that might occur from the use of patient photography, videotaping, digital imaging, and other visual recordings during patient care or other health system activities. Consent must be obtained before any patient photography. Specific written authorization must be obtained before any patient photography will be released.

PROCEDURE

I. **DEFINITIONS**

Patient Photography: The likeness of a patient may be recorded through a number of visual means, including still photography, videotaping, digital imaging, scans, and others. Throughout this document, the term "patient photography" will be used for any such recording of a patient's likeness.

HIPAA: The standards for privacy of individually identifiable health information, also known as the final privacy rule from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), address photographs and similar images both directly and indirectly.

Section 160.103 defines health information in a manner that implies inclusion of patient photography:
"Health information means any information, whether oral or recorded in any form or medium, that:
(1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and
(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of healthcare to an individual."

Section 164.514(b)(2), Implementation Specifications: Requirements for De-identification of Protected Health Information, photographic and comparable images are explicitly noted

as an item to be removed during de-identification in order for records to avoid the protected health information status and fall outside the regulations:

"A covered entity may determine that health information is not individually identifiable health information only if:

(2)(i) the following identifiers of the individual or of relatives, employers, or household members of the individual, are removed:

(Q) Full face photographic images and any comparable images"

II. CONSENT TO PHOTOGRAPH

1. Specific consent shall be obtained prior to photographing the patient from the parent(s) or legal guardian **for all purposes except** in cases of abuse, neglect or in emergencies; and photography obtained for personal/family use, (e.g. photographs used for family photo albums, or other private use).

2. Written consent shall be obtained using the top section of the Form: *Consent to Photograph and/or Authorize the Release Of Information.* See attachment to policy.

3. Completed consent form will be retained in:
   - Medical Records – Consents for photography for medical documentation, special procedures, diagnostic tests, surgical procedures, etc.
   - Audio Visual (AV) department – Consents for photography used for education and teaching.
   - Public Relations department – Consents for media, publications and marketing.

III. AUTHORIZATION FOR RELEASE OF PHOTOGRAPHY

The second section of the form: *Consent to Photograph and/or Authorize the Release Of Information*, should be used when the individual/parent/legal guardian requests the release of patient photography.

Unless otherwise required by federal or state law, photographs and other images should not be released to outside requestors without specific written authorization from the patient or parent(s)/legal guardian. The authorization should state that the patient agrees to have the photographs released to the requestor and the purpose for which they will be used. The use and release of the photography depends on the purposes for which the photography was taken.

A. **Medical Documentation:**

1. Photographs are considered health care records and will be retained and released in accordance with applicable regulation and statutes. The parent(s) or legal guardian may request copies of these photography items as they do the medical record.

B. **Teaching, Education And Research:**

1. In general all reasonable efforts should be taken to protect the anonymity of the patient in teaching, education and research patient photography.
2. Teaching, education or research patient photography are not a part of the patient's medical record. As such, the parent(s) or legal guardian does not have access to these items of photography.
3. Photography associated with a research study, should use the Research Consent Form to obtain the consent of the research participants.

C. **Public Relations And Advertising:**

1. No patient photography taken in the Hospital will include identifiable images of other patients from whom similar approval to photograph has not been obtained.

IV. SUMMARY CHART

Photography		
Purpose of Photography	**Consent Required**	**Authorization Required**
Photography for Patient/Family Personal/Private Use	No	No
Patient Care Documentation	Yes	No, if PHI being released for treatment, payment or healthcare operations
Diagnostic or Therapeutic Procedures/Surgery, excluding endoscopy and other procedures where photography is part of the procedure and patient is not identifiable.	Yes	
Teaching/Medical Education	Yes	Yes
Publicity/Marketing	Yes	Yes
Documentation of Abuse or Neglect	No	No, unless used for other purposes, than need authorization
Research	Yes	IRB
Media	Yes	Yes
Web site/Internet	Yes	Yes
Law Enforcement	See **	**Depends on Law Enforcement Purposes.

V. DURATION OF CONSENT/AUTHORIZATION

1. The consent/authorization for release of photography is valid for one year from the date of dated signature. This means that the consent/authorization provides permission to use the photography for as long as it remains within the original purpose.
2. After 1 year, any new use or release of the photography requires a new authorization.

VI. RETENTION AND STORAGE OF PHOTOGRAPHY

1. All photography is retained according to the Children's Hospital and Health System Policy, "Privacy – Record Retention"

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Jon E. Vice, President

Children's Hospital and Health System™

Part 1:
Consent to Photograph

Directions: This is a 2 part form:
Complete part one, form C2137N "Consent to Photograph" if only photography is being requested.
Complete part two, form C2138N "Authorization for the Release of the Photographs or Other Media" if requesting a copy for use by self or other party.
Complete both C2137N and C2138N if photo is requested and a copy will be released.

CONSENT

Individual's Name _____ Birth Date: _____

Address _____

City _____ State _____ ZIP _____

Home Telephone Documentation Number (_____) _____

I consent to the taking of photography, videotaped images or other images to be made of my myself / child (circle one or both) for the purposes of (check all that apply):

- ☐ Medical documentation (original goes in medical record)
- ☐ Teaching, education
- ☐ Publicity, publications
- ☐ Marketing
- ☐ News media, including newspapers, magazines, wire services, television & radio stations
- ☐ Other _____
- ☐ Interview with news media

Name of Department Responsible for storage of Photography/Video: _____

Signature of Individual/Parent/Legal Guardian: Name _____ Date _____

Authorization/Relationship to Individual:
- ☐ Self
- ☐ Parent
- ☐ Guardian
- ☐ Legal Representative authorized by the Individual

Witness (when applicable): _____

Relationship _____ Date _____

PROOF COPY

C2137N (3/05) Original- Medical Record or Department Copy- Parent

DT136

Children's Hospital and Health System™

Part 2: Authorization for the Release of Photographs or Other Media

Directions: This is a 2 part form:

Complete part one, form C2137N "Consent to Photograph" if only photography is being requested.

Complete part two, form C2138N "Authorization for the Release of Photographs or Other Media" if requesting a copy for use by self or other party.

(1) I hereby authorize CHHS to disclose the following photographs or other media to:

Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Individual MRN when applicable: _____

Covering the period(s) of healthcare: From (date) _____ to (date) _____

(2) Type of Information to be disclosed:

☐ Photographs, videotapes, digital or other images (Non-Sensitive Information)

☐ Other (please specify) _____

☐ Interview with news media, including newspapers, magazines, wire service, television & radio station

☐ Release of one-word condition reports

(3) Information is to be disclosed to _____ for the purpose of _____.

(4) PHI Delivery Options: ☐ **Fax** ☐ **Mailed** ☐ **Telephone** ☐ **Pick-up**

Authorized person to pickup requested PHI if different than name listed above:

Last Name _____ First Name _____ Middle Initial ____

Relationship to Individual _____ Date & Time to be picked-up _____

(5) This authorization is valid until the following Date(s)/event: _____.
If no date is specified, this Authorization will expire one (1) year from the date signed.

(6) I agree that all reproduction and all copyrights associated with the above described information and media are and shall remain the property of CHHS, its successors and/or assigns. I agree not to request or accept any payment or other consideration in exchange for signing this agreement and for the use of any of the above photography or media materials.

(7) **PROHIBITION ON RE-DISCLOSURE: Federal and Wisconsin Confidentiality laws protect this information.** Such laws prohibit the redisclosure of such information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by such laws. However, I understand that the information disclosed may be potentially redisclosed by the recipient and may no longer be protected by the federal privacy and confidentiality rules.

I have had an opportunity to review this and understand the content of this authorization. I understand that this Authorization is voluntary. CHHS will not condition your treatment, payment, and enrollment in a health plan or eligibility for health care benefits based on my decision to sign this Authorization.

I understand that I have a right to revoke this authorization at anytime. I can do so by submitting my revocation in writing to the Medical Records Department. I understand that my revocation will not apply to information that has already been released in response to this authorization.

By signing this Authorization, I am confirming that it accurately reflects my wishes.

A photocopy or facsimile of this Authorization is valid as the original.

(8) Signature of Individual/Parent/Legal Guardian:

Name _____ Date _____

Authorization/Relationship to Individual: ☐ Self ☐ Parent ☐ Guardian
☐ Legal Representative authorized by the Individual

(9) Witness (when applicable): _____

Relationship _____ Date _____

C2138N (3/05) Original - Medical Record or Department Copy - Parent

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