LOMA LINDA UNIVERSITY
HEALTH

INTERNATIONAL Consent Form Instructions

For articles and stories written and/or photos and videos taken overseas on behalf of Loma Linda University Health.

(1) LLUH Employees, Students and Volunteers

All LLUH employees, students and volunteers who have not previously signed the ***Consent Form*** within the last year, must fill and sign the highlighted portions of the ***Consent Form***.

Expiration Date: Unless otherwise indicated by the signee, please enter a date **ten years** from the date the form is signed.

(2) Other Individuals and Professionals

All other individuals and professionals featured in a posed photo (not a public event) must fill and sign the highlighted portions of the ***Consent Form***.

Expiration Date: Unless otherwise indicated by the signee, please enter a date **ten years** from the date the form is signed.

2137

AUTHORIZATION AND CONSENT TO RECORD AUDIO AND/OR VIDEO, PHOTOGRAPH, WRITE, AND PUBLISH

I, _____ (print full legal name), the undersigned, do hereby authorize Loma Linda University Health (LLUH), its affiliates, and its designated representatives to record identifiable/non-identifiable audio and/or video, to take identifiable/non-identifiable photographs, write, publish, and distribute identifiable/non-identifiable information about me and/or the dependent named below for whom I serve as legal guardian, in such manner as LLUH, its affiliates, and its representatives deem appropriate.

I further authorize LLUH, its affiliates, and its designated representatives to publish any identifiable/non-identifiable photos or other assets that I provide for their use _____ (initial ONLY if providing media assets).

I agree that LLUH, its affiliates, and its designated representatives may use and permit others to use all media forms known now or created in the future and/or written information as deemed appropriate for such purposes including, but not limited to, dissemination to LLUH and its affiliates' staff, physicians, health professionals, students, and members of the public for educational (e.g. teaching/conferences), treatment, research, scientific, public relations, marketing, news media, and/or charitable purposes. I agree that such dissemination may be accomplished in any manner and publication medium deemed appropriate by LLUH, its affiliates, and its designated representatives, and that such dissemination is subject only to the following limitations: NO LIMITATIONS

I understand authorizing the use/disclosure of the information identified above is voluntary.

I need not sign this form to ensure health care treatment. I understand that I have the right to revoke this authorization at any time by submitting my request in writing to the department indicted on the bottom of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to any insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, or expired, this authorization will remain valid.

I understand that I may inspect or obtain a copy of the information to be used/disclosed, as provided in 45CFR164.524. I understand that any use/disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about use/disclosure of my health information in general, I can contact the Health Information Management Department at (909) 651-4191. For questions about the use/disclosure of my health information for publication purposes, I may contact the Advancement Department at (909) 558-4544.

I agree to assist LLUH, its affiliates, and its designated representatives in pursuing scientific, treatment, educational, public relations, marketing, news, and/or charitable goals, and I do hereby waive my rights and/or the rights of my dependents/successors to compensation for such uses. I, the undersigned, and my dependents/successors will hold LLUH, its affiliates, and its designated representatives harmless from and against any claim for injury and/or compensation resulting from the activities authorized by this agreement.

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Loma Linda University Children's Hospital
Loma Linda University Health Care
Loma Linda University
Loma Linda University Behavioral Medicine Center
Loma Linda University Medical Center – Murrieta
Loma Linda University Health Highland Springs Surgical Center

LOMA LINDA UNIVERSITY HEALTH

AUTHORIZATION AND CONSENT TO RECORD AUDIO AND/OR VIDEO, PHOTOGRAPH, WRITE, AND PUBLISH

Page 1 of 3

PATIENT IDENTIFICATION

CONSENT FORM PAGE 1

I understand this authorization expires (insert date): 10/01/28 or at the end of day 365 from today's date if an expiration date is not provided.

Upon expiration of this authorization, LLUH, its affiliates, and its designated representatives will not permit further release of any photographs, audio recordings, videos or any other information, but will not be able to call back any photographs, audio recordings, videos or any other information already released.

Signature: _____ Date/Time: _____
(Patient/Non-patient/Legal Representative)

Print Name: _____ DOB/Last four SSN: _____
(For patients only)

Address*(optional)*: _____

Phone: _____ Email: _____

If signing as legal guardian for another individual, please print your dependent's name and your relationship to him/her:

Dependent's Name: _____ Relationship: _____

Witness: _____ Date/Time: _____

Patient/Guardian Authorization to Contact Health Care Providers and/or Publish Protected Health Information

I, _____ (print full legal name), do hereby authorize LLUH, its affiliates, and its designated representatives to speak with health care providers about my care, or that of the dependent named above for whom I serve as legal guardian, regarding Protected Health Information deemed pertinent and appropriate for the purposes and limitations listed on this authorization form. I also authorize the publishing of that Protected Health Information according to the terms of this authorization.

Signature _____ Date _____

LLUH Health Information Management (HIM) **101 E. Redlands Blvd., Suite #1200** **San Bernardino, CA 92408** **Ph: (909) 651-4191**	LLUH Advancement **P.O. Box 2000** **Loma Linda, CA 92354** **Ph: (909) 558-4544**

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PATIENT IDENTIFICATION

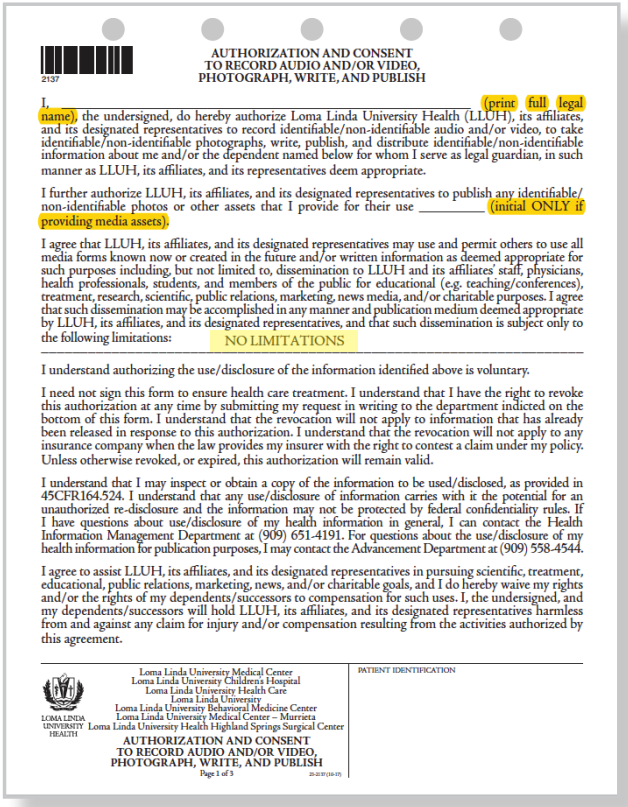
CONSENT FORM PAGE 2

(3) Adult Patients past or present or patients at a health fair

If the photo taken depicts **LLUH adult patients and/or LLUH employees, students or volunteers treating an adult patient** at a clinic, health fair or otherwise, (i.e. blood pressure, etc.) the patient must fill and sign the highlighted portions of the ***Consent Form*** ***and must also provide*** only the last 4 digits of their Social Security Number or full Date of Birth.*

The signed document must then be properly secured to prevent unauthorized access to it. Submit the consent form concurrently to the Office of Marketing & Communications and to the Health Information Management (HIM) Department in order to have it scanned into individual systems i.e., Razors Edge and the patient's health record.

Expiration Date: Unless otherwise indicated by the signee, please enter a date **100 years** from the date the form is signed.



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AUTHORIZATION AND CONSENT
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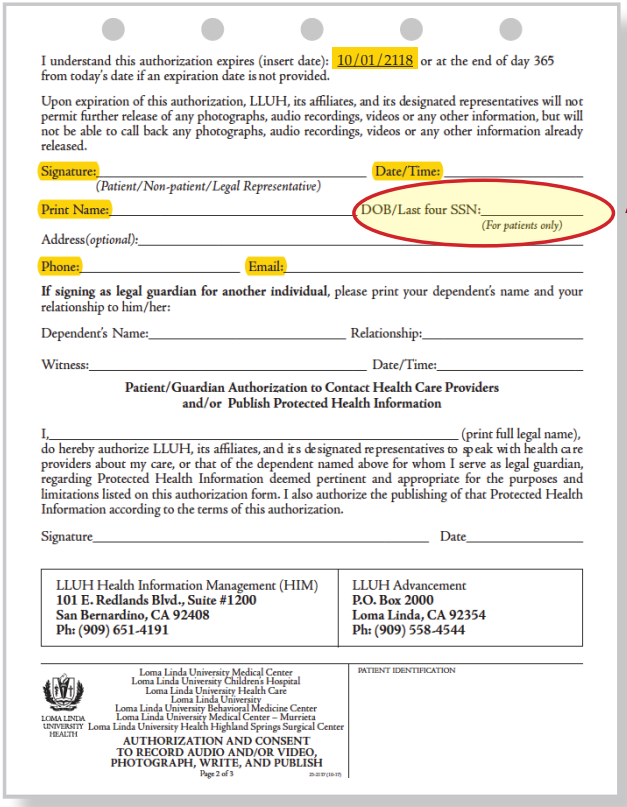
PATIENT IDENTIFICATION

CONSENT FORM PAGE 1



I understand this authorization expires (insert date): 10/01/2118 or at the end of day 365 from today's date if an expiration date is not provided.

Upon expiration of this authorization, LLUH, its affiliates, and its designated representatives will not permit further release of any photographs, audio recordings, videos or any other information, but will not be able to call back any photographs, audio recordings, videos or any other information already released.

Signature: _____ Date/Time: _____
(Patient/Non-patient/Legal Representative)

Print Name: _____ DOB/Last four SSN: _____ *
(For patients only)

Address *(optional)*: _____

Phone: _____ Email: _____

If signing as legal guardian for another individual, please print your dependent's name and your relationship to him/her:

Dependent's Name: _____ Relationship: _____

Witness: _____ Date/Time: _____

Patient/Guardian Authorization to Contact Health Care Providers and/or Publish Protected Health Information

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Signature _____ Date _____

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PATIENT IDENTIFICATION

CONSENT FORM PAGE 2

(4) Minors and Minor Patients > Parent/Legal Guardian

If the photo taken depicts a **minor under the age of 18** (not at a public event) the legal guardian of the minor must fill and sign the highlighted portions as well as the legal guardian section on page two of the ***Consent Form***. If the **minor is a patient**, the legal guardian ***must also provide*** only the last 4 digits of their child's Social Security Number or full Date of Birth.*

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PATIENT IDENTIFICATION

CONSENT FORM PAGE 1

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Signature: _____ Date/Time: _____
(Patient/Non-patient/Legal Representative)

Print Name: _____ DOB/Last four SSN: _____ *
(For patients only)

Address *(optional)*: _____

Phone: _____ Email: _____

If signing as legal guardian for another individual, please print your dependent's name and your relationship to him/her:

Dependent's Name: _____ Relationship: _____

Witness: _____ Date/Time: _____

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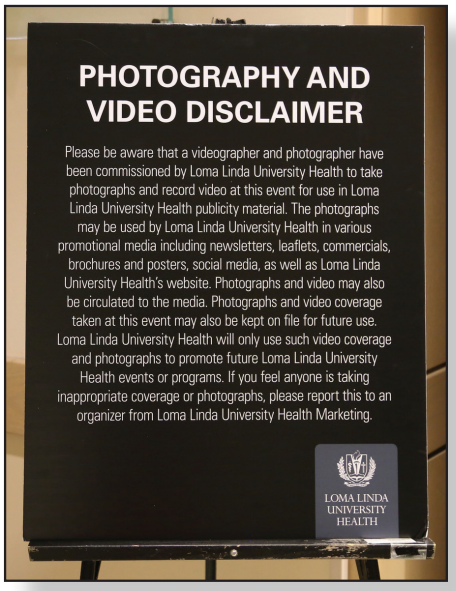
(5) Presentations, Public Events or Commencement Ceremonies

For presentations, public events or commencement ceremonies, please post the ***Photography and Video Disclaimer Sign*** at a registration table, main entrance or stage front at the event ***and take a picture*** of the displayed sign at each event.

While photographing at the public event, please note that individual requests by photographed subject(s) to not have their photograph taken must be honored. If the photograph has already been taken, it must be deleted and that action communicated back to the subject in the photograph.



PHOTOGRAPHY AND VIDEO DISCLAIMER SIGN

CONSENT FORM NOT REQUIRED

Community Members:

☒ Photos that are taken in a public setting (outdoor market, etc.) of minors or adults a ***Photo Consent Form is not required***.

☒ If the photo is a close-up of individuals clearly smiling or posing for the camera a ***Photo Consent Form is not required***.

Please submit non-PHI consent forms to:

DJ Potts, Global Health Institute, djpotts@llu.edu

Please submit PHI consent forms to:

Kimberly Jones, HIM Deparment, 101 LLUH Building

Questions?

Compliance Department
909-558-6310

Secured in an envelope that reads:

The documents contained herein are the property of Loma Linda University Medical Center (LLUMC) or Loma Linda University Health (LLUH) and are CONFIDENTIAL in nature. If you are the intended recipient, you are required to protect the documents from unauthorized use, access or disclosure. If you are not the intended recipient, please immediately return the documents unopened to the Compliance Department located at the LLUAHSC Support Services building (101 East Redlands Boulevard, Suite 1400A, San Bernardino, CA 92408) or call 909-651-4200 and an authorized employee will arrange to pick-up the documents.