Boston Maxillofacial Prosthetics

Maxillofacial Prosthetics & Oral Oncology

IDENTIFICATION AREA

Part 1 of 2
Consent for Photography and Recordings for Non-Clinical and Non-Research Purposes

I _____ give my permission, as shown below, to be interviewed, photographed, video/audio recorded, or broadcast/webcast live, (each a "Recording"), during interviews, diagnostic/treatment sessions, surgical/medical procedures, celebrations or events.

I am consenting to: *(check all that apply)*
☐ Interview ☐ Photographs/Digital Images ☐ Live Broadcast/Webcast
☐ Audio Recordings ☐ Video Recording/Motion Pictures

I agree that BMP may use these Recordings and my information for *(check all that apply)*:

Education and training:

☐ Within BMP

☐ Outside of BMP

Inform the public about clinical, educational, scientific, and charitable activities or services of conjunction with:

☐ Live or taped television, radio or internet broadcasts

☐ Publications including, but not limited to, articles in a medical journal, newspaper, hospital magazine/ newsletter/website, print/online

Other: ☐ _____

I understand that all information provided by me or my care team during the Recordings may be used and disclosed for these purposes. This may include personal or health information about me.

I also understand and agree that:

- I grant and release to BMP all rights, title and interest that I may have in these Recordings, including copyrights in the Recordings and rights to use, reproduce, modify, create derivative works of, broadcast and distribute the Recordings.
- My participation is voluntary. I will not receive, and I am giving up any claim to receive, any payment or royalties in connection with any use or disclosure of the Recordings.
- Only individuals who are approved by BMP shall conduct or produce the Recordings.
- If any of the Recordings are given to a third party outside BMP , such as the media, BMP cannot control how they will use or share the Recordings.
- The Recordings may be edited, modified, or retouched for artistic and graphic production reasons or to withhold identity.

I ☐**do** ☐**do not** authorize my name to be used in connection with these Recordings.

If the Recordings will be shared outside of BMP **in any public forum or manner** and they contain information that could be used to identify me (such as: my name, face, voice, demographics) and reveal information about my medical conditions or treatment, I must also sign a HIPAA authorization form (See page 2).

Name of Individual	Date of Birth	Signature	Date

(If Applicable) Name of Legally Authorized Representative	Signature	Date

Relationship of Representative to Individual: _____

Print Staff Representative Name, Title and Entity	Signature	Date

PLEASE RETAIN A COPY OF YOUR SIGNED AUTHORIZATION FORM FOR YOUR RECORDS

Boston Maxillofacial Prosthetics

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IDENTIFICATION AREA

Part 2 of 2
Consent for Release of Information Outside of for Non-Clinical and Non-Research Purposes

I authorize BMP to use and release personal information about me, including health information, medical history, diagnoses, medical care, and treatment for the following purposes: *(check all that apply)*:

☐ Education and training outside of BMP _____

Inform the public about clinical, educational, scientific, and charitable activities or services of the Hospital in connection with

☐ Live/taped television, radio or internet broadcasts

☐ Publications including, but not limited to, articles in a medical journal, newspaper, hospital magazine/newsletter, print/online

☐ Other: _____

Authorized Information: I separately consented to BMP taking interviews, photographs, digital images, video recordings/motion pictures and/or audio recordings of me during interviews, diagnostic or treatment sessions, surgical or medical procedures, celebrations and other events ("Recordings"). BMP may use and release these Recordings according to my Consent for Photography and Recordings (attached hereto), and release personal information about me, including medical history, diagnoses, medical care and treatment in accordance with such Consent and this HIPAA Authorization. **I understand that I can be identified from these Recordings and my information will no longer be protected by privacy laws once released**.

I understand that BMP requires my specific authorization to release information about the following counseling/treatment/tests Checking ***"Yes"*** gives BMP my permission to release the information. Checking ***"No"*** means I do not give my permission to release the information, or it is not applicable.

Yes ☐ No ☐ HIV test results, status, counseling or treatment

Yes ☐ No ☐ Genetic Screening Tests Results

Yes ☐ No ☐ Treatment for Substance Use Disorder. This consent may be revoked upon oral or written request.

Yes ☐ No ☐ Mental Health Diagnosis and/or Treatment by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, Licensed Mental Health Clinician or Licensed Social Worker

Yes ☐ No ☐ Intimate Partner Abuse Counseling

Yes ☐ No ☐ Sexual Assault Counseling

<u>I understand that</u>:

- I may refuse to sign this authorization. This will not affect my treatment, payment, health plan enrollment, or eligibility for benefits. However, I may not be able to be part of the Recording.
- I may change my mind and take back this authorization **except if the authorized action has already been taken**. I understand BMP cannot get back copies of the Recordings and information once they have been released to third parties. Once released to third parties, BMP has no control over how the third parties use, disclose or protect the Recordings and information.
- *To take back this authorization*: Write to: _____Fax and phone number: _____.
- This authorization remains in effect until the Recordings and information are no longer needed for the above-indicated purposes unless I specify otherwise in the space provided below. I understand that BMP cannot prevent third parties, such as the media, who may have received the Recordings and information, from continuing to use them after this authorization has expired. Authorization expires: _____.

I have carefully read and understand this form and have had my questions answered to my satisfaction. I expressly and voluntarily authorize BMP to use and disclose the Recordings and information as set forth above:

_____

Name of Individual Date of Birth Signature Date

_____

(If Applicable) Name of Legally Authorized Representative Relationship Signature Date

PLEASE RETAIN A COPY OF YOUR SIGNED AUTHORIZATION FORM FOR YOUR RECORDS