Maryland
DEPARTMENT OF HEALTH

PATIENT PHOTO/RECORDING & INFORMATION RELEASE AUTHORIZATION FORM

NOTE: *This form is* ***NOT*** *required for photos or recordings (audio or video) of patients used for the purposes of treatment or diagnosis, where the photo and/or recording (audio or video) becomes part of the patient's medical record and is not used for any other purpose.*

1 Photography/Recording Release:

I authorize the Maryland Department of Health (MDH) to take photos and/or recordings (audio or video), or to allow third parties to take photos and/or recordings (audio or video), of _____ for the following uses:

Patient Name

Check all that apply

For Public Relations Purposes

- ☐ On MDH internet and intranet sites
- ☐ In MDH publications and brochures
- ☐ In the public media, such as newspapers, magazines, on the internet (e.g. social media sites), and on television or radio
- ☐ In presentations, publications, brochures, advertisements, or articles by non-MDH agencies or companies, such as other non-profit organizations or for profit companies who provide support to MDH

For Medical or Educational Purposes

- ☐ In professional journals and other publications, including textbooks and electronic publications
- ☐ In presentations by MDH faculty, staff, and employees, including professional and educational conferences or seminars
- ☐ In MDH classrooms and other teaching environments
- ☐ Other: _____

☐ **I understand that the image(s) and/or recordings (audio or video) I've authorized for disclosure may be seen by scientists, medical researchers, medical students, teachers, staff and members of the general public in accordance with the selected choices.**

2 Information Release:

☐ **I consent to the use of my name.** I understand that I may be identified by name in printed, internet or broadcast information that might accompany the image or recording of me.

-OR-

☐ **I do not consent to the use of my name.** I understand that, even though my name will not be used, it is possible that someone may recognize me based on the image(s) or recording(s) alone.

☐ I authorize the use of the following information about me, my medical condition, or my treatment**:** _____

3 **This authorization expires one year from the date the form is signed unless I indicate an earlier date or event *(must occur sooner than 1 year from the date of my signature)* here:**

Until Date: _____ **OR** Until specific event: _____

4 **I have read this authorization form and understand the following:**

a. By signing this form, I am authorizing photography/videography/audio recording and information release in accordance with the choices specified in section 1 and section 2.

b. I may revoke this authorization at any time by writing to the individual, program, organization or facility to which this form was submitted.

c. If the individual, program, organization or facility provided this authorization has already released health information based on this authorization, revoking it will only prevent future disclosure by the individual, program, organization or facility to which this form was submitted.

d. Images and information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected by federal and state privacy laws.

e. My treatment, payment for my treatment, enrollment or eligibility for services/benefits cannot be conditioned on the signing of this authorization.

5 **Patient Signature** _____ **Date** _____

Parent or Personal Representative Signature *(if applicable)* _____ **Date** _____

If signed by Parent or Personal Representative, please indicate Relationship to Patient

☐ Parent of Minor Child ☐ Guardian ☐ Authorized Representative

☐ Other _____