G-2d$_p$ CONSENT FOR PHOTO, VIDEO, AND/OR AUDIO MONITORING/RECORDING OF PATIENTS

Monitored Telephone Consent recorded electronically via Epic
Dotted lines to be completed by patient or representative as applicable.

•This completed form must be scanned in Epic•

DATE

HOSP.#

NAME

BIRTH DATE

IF NOT IMPRINTED, PLEASE PRINT DATE, HOSP. #, AND NAME

UIHC staff: To obtain Monitored Telephone Consent, contact the hospital operator; these consents are then electronically recorded in Epic. ***Consents for publication, marketing or research purposes, or for non-patients, should use other applicable forms.*** *It is not required to have the patient's written consent to take a photo/recording to augment clinical documentation within the medical record. Captured images will include only the minimum and relevant image capture necessary to satisfy the specified and consented purpose. Staff must not use their personal cell phones or other personal equipment to photograph, video monitor/record, or audio record patients unless the device is Haiku/Canto enabled. Refer to policy "Photography, Video and Audio Recording of Patients" RI-PR-05.58.*

I, the patient or legal representative for the patient as named above, do agree to the use of the following electronic recordings. (Please check as applicable.)

_____ Photographs _____ Video monitoring _____ Video recording _____ Audio recording

I understand that the photos or recordings may be used for the following purposes. (Check as applicable.)

_____ Telemedicine (live transmissions, e.g. Skype, FaceTime, Polycom, etc.) needed for diagnosis or treatment by University of Iowa Health Care staff. University of Iowa Health Care makes no assurances of the privacy of live transmissions. These images/recordings may be captured and stored, and if so will be part of my/the patient's medical record.

_____ Internal educational purposes (i.e. resident teaching, operative planning, etc.)

_____ Internal operational purposes (i.e. performance improvement, quality review, etc.)

_____ External educational purposes (i.e. provider/specialist lectures with no patient identifying information)

_____ Viewing of pre-operative and post-operative images by future patients within UIHC

_____ Other, explain _____

This authorization is valid for an indefinite period of time or as indicated _____.
(specify # of months/years)

I understand that photographs or recordings that are used for educational or operational purposes may be a part of my/the patient's medical record. My questions have been satisfactorily answered.

Signature _____ **Date** _____
(Patient or person authorized to consent for patient)

_____ _____
(Printed name of person signing) (Relationship to Patient)

Staff Signature: _____ **Date:** _____ **Time:** _____
(Person who obtained consent)

Printed Name: _____
(Person who obtained consent)

UNIVERSITY OF IOWA HOSPITALS AND CLINICS
200 Hawkins Dr., Iowa City, IA 52242

UNIVERSITY OF IOWA HEALTH CARE | Aesthetic Consultants of Iowa
PLASTIC AND RECONSTRUCTIVE SURGERY

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319-393-1867 Fax
www.lookmybestnow.com or
www.uihealthcare.org/plastic-and-reconstructive-surgery

Name:_____

Date of Birth:_____

Dear Patient,

The American Board of Plastic Surgery requires that I inform you that I may use your photo in the materials I submit for board certification.

The Board requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Examination of The American Board of Plastic Surgery to protect patient privacy.

"I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing, and/or certifying purposes by The American Board or Plastics Surgery, Inc."

_____Patient Signature

_____Witness Signature

_____Date

Thank you,

Patrick J. Hawkes, MD