

CONSENT TO PHOTOGRAPHY - CASE REPORT

Instructions to ETSU Health Faculty and Staff

This form must be used if you plan to take case status photographs for inclusion with your case report.

A copy of each completed form should be stored with your case report materials.

Please fill out the **highlighted** section prior to the patient signing this form and delete this instructions page.

If at any time during this process you have questions, please do not hesitate to contact the HIPAA Compliance Office. We will be happy to assist you.

HIPAA Compliance Office

Burgin Dossett Third Floor | Box 70285

☎: 423.439.8533

✉: hipaa@etsu.edu

CONSENT TO PHOTOGRAPHY – CASE REPORT

I, _____, authorize East Tennessee State
Patient Printed Name

University, Medical Education Assistance Corporation, and the Northeast Tennessee Community Health Centers, Inc. (collectively referred to as “ETSU Health”), and their respective assigns, licensees, and legal representatives, to take my photograph (including, but not limited to, full face images) for a case report relating to any condition, illness, or injuries I may suffer.

A case report is a medical or educational activity that involves the presentation and/or publication of information and analysis for the purpose of highlighting an interesting or unique clinical experience, observation, treatment, relationship, or outcome. A case report may be published in paper or electronic form for others to read. A case report may also be presented at a conference or meeting.

Once the case report is published or presented, your health information including any photographs, images, or other recordings may no longer be protected by federal and state privacy laws. This means this information may be re-disclosed without asking your permission

Revocation: You can change your mind and cancel this authorization at any time. If you want to change your mind, you must let ETSU Health know in writing to:

If you change your mind, ETSU Health will not be able to take back the information that has already been used/disclosed under this authorization.

Expiration Date: This authorization will expire when the intended purpose has been fulfilled.

You do not have to sign this form. If you refuse to sign this form, your medical treatment will not be affected. By signing below, you confirm that you had an opportunity to review this form and ask questions. By signing below, you confirm that this form accurately reflects your wishes.

Signature of Patient or Legally Authorized Representative Date

If this document is signed by someone other than the Patient, such as a person holding a Durable Power of Attorney for Healthcare, the signer must state his/her relationship to the Patient, describe his/her authority to act on the Patient’s behalf, and provide a copy of the Durable Power document:
