FORM 24-3

Consent to Photograph

This form is to be used only for photographs taken for treatment or the hospital's own health care operations. Photography for other purposes (e.g., research, publication, outside education, marketing, public relations, news or documentary) requires use of the form "Consent to Photograph and Authorization for Use and Disclosure (CHA Form 24-4).

I hereby consent to be photographed while receiving treatment at the hospital.

I understand that the images from such photography may be used for my treatment or for hospital health care operations such as peer review or medical education, as the hospital or my treating physician(s) deem appropriate. The use of such images is subject only to the following limitations:

_____

_____

The term **"photograph"** as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Original: Medical Record

Copy: Patient

FORM 24-3S

Consentimiento Para Tomar Fotografías

This form is to be used only for photographs taken for treatment or the hospital's own health care operations. Photography for other purposes (e.g., research, publication, outside education, marketing, public relations, news or documentary) requires use of the form "Consent to Photograph and Authorization for Use and Disclosure (CHA Form 24-4).

Por este medio, autorizo para que me tomen fotografías mientras recibo tratamiento en el hospital. Entiendo que las imágenes de dichas fotografías se pueden utilizar para mi tratamiento o para operaciones de atención médica propias del hospital, tales como revisión entre colegas o educación médica, de acuerdo con lo que el hospital y el o los médicos que me traten consideren conveniente. El uso de las imágines está sujeto únicamente a las siguientes limitaciones:

_____

_____

El término **"fotografía"**, según se usa en la presente, incluye fotografía estática o en video, en formato digital o en cualquier otro formato, así como cualquier otro medio de grabar y reproducir imágenes.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Original: Medical Record

Copy: Patient