University of Michigan School of Dentistry **Request and Consent to Photography and/or Video Record**	UMSD EHR: NAME: BIRTHDATE:

Your provider may need to photograph and/or record (audio or video) you to document a medical condition, to help with the diagnosis and/or treatment of a condition, and/or to help plan the details of surgery. Photographs and/or recordings taken for these clinical reasons do not require your written permission**. Your provider does need your written permission to use your photographs and/or recordings for the non-clinical reasons below.**

I hereby authorize the (Name of service, clinic, or department) _____, including other designated person(s), to photograph and/or record me for the following purposes: Check **YES** or **NO**.

	YES	NO
1. For the advancement of **not-for-profit** medical purposes, including teaching, research and education. I understand that education is an important part of the School's commitment to teaching healthcare providers.	☐	☐
2. To show or release to current or future UMSD patients for the purpose of education and consultation. I understand these photos or recordings can be taken at any time during my treatment which includes pre-treatment, post-treatment, pre-operative, intra-operative, post-operative photos, and/or recordings of my treatment, surgery and/or procedure.	☐	☐
3. For external educational purposes outside UMSD such as lectures and presentations at professional conferences, publishing in journals or textbooks, licensing and certification activities.	☐	☐

I consent to photographs and/or recordings under the following conditions:

- Copies of the photos, audio, videos, and/or films may be released to me if I ask for them.
- I can refuse to have photos and/or recordings taken without any change in my care at UMSD.
- I understand and agree that although my name will not be used, it may be possible to identify me from a photo and/or recordings and
- I understand that once released outside UMSD, UMSD does not have control over the photos or recordings.

Revoking Permission: This authorization has no expiration date; but I may revoke it at any time by writing to the Office of Patient Services – Central Records at the address below. I must state in writing that I no longer give consent for photography and/or recording and for the use of any photo(s) or recording(s) that were already taken.

I have had enough time to discuss with my provider the information on this form. I have had the chance to ask questions and my questions have been answered. I have read and understand the information. I hereby release the School of Dentistry, its personnel, and any other persons participating in my care for any and all liability which may or could arise from the taking or authorized use of such photographs and/or recordings.

_____ _____/_____/_____

Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) Date (mm/dd/yyyy)

_____

Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)

Relationship: ☐ Spouse ☐ Parent ☐ Next of Kin ☐ Legal Guardian ☐ DPOA for Healthcare

_____ _____/_____/_____

Explained and Witnessed by Date (mm/dd/yyyy)

University of Michigan School of Dentistry
1011 N. University Avenue Room B390, Ann Arbor, MI 48109-1078
Phone: (734)- 764-6152 Fax: (734)-615-7040

TO PROVIDERS: Photographs and/or recordings (audio or video) taken for a clinical purpose do not require written consent. The photographs or recording will be made part of the health record. Written consent must be obtained prior to taking and/or using a photograph and/or recording for non-clinical purposes. If a photograph or recording is initially taken for a clinical purpose, and later deemed appropriate for a non-clinical purpose, written consent must be obtained prior to using h the photograph or recording for the non-clinical purpose. For photography and/or recording of patients related to research, please refer to the IRB website. For photography and/or recording of patients for use in promotional or marketing materials, please use form: Permission to Release Information Including Photographs, Videos, Electronic or Other Media.

Copy: UMSD
EHR