San Francisco Department of Public Health
Consent to Record / Authorization for Publication

INDIVIDUAL BEING RECORDED* (PRINT)	
DATE OF BIRTH*	MRN (If Patient)
ADDRESS	
PHONE	LANGUAGE
EMAIL	

Failure to provide ALL information marked * may invalidate this authorization

I* (print), _____ (AKA) _____ consent to and authorize the San Francisco Department of Public Health (SFDPH), its employee, and/or agent to record me (or my dependent) for the purposes of assisting in scientific treatment, education, public communications, and/or charitable goals. Recordings refer to identifiable photographs, digital images, scans, motion pictures, videotapes, computer feeds, images (paper or electronic), or audio recordings.

1. I understand that authorizing this recording is voluntary.
2. I understand that I shall not be denied treatment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.
3. I understand that I have a right to receive a copy of this authorization.
4. I understand that information disclosed as a result of this authorization could be re-disclosed by the individual, agency or public who views or receives this recording.
5. I understand that I may request recording to stop at any time.
6. I also understand that when I give or cancel my authorization, it is effective from that date forward and not retroactively. **Once my recording is released through this authorization, I understand the SFDPH may not be able to stop others (including the public) from viewing my recording in the future, even if I cancel my authorization.**
7. I understand that I will not be paid for the use or disclosure of my recording.
8. **Expiration*:** Unless I cancel it, this authorization expires on the date noted below. <u>If no date is given, authorization will expire one year from the date authorized.</u>
9. I hereby hold harmless the San Francisco Department of Public Health, its employees, and agents participating in this recording from and against any claims related to this recording.

Purpose of Publication / I hereby authorize the use or disclosure for recording and publication *			
Person/organization authorized to receive the information outside of SFDPH *			
Date Authorized*	Time Authorized	Date of Expiration*	
Authorizer's Signature*	Authorizer's Printed Name if other than individual being recorded*: __Parent __Guardian __Other:_____		
Witness Signature	Witness Printed Name	Interpreter Signature	Interpreter Printed Name

SFDPH Signature (Employee/Agent obtaining authorization)	Printed Name (Employee/Agent obtaining authorization)