TEXAS Health and Human Services | Texas Department of State Health Services

Tuberculosis and Hansen’s Disease Unit

# Photo Release and Disclosure

This form is a consent for medical photography that may be used during or after treatment in a Texas Department of State Health Services (DSHS) Hansen’s Disease Clinic.

______________________________________________________________

Health Department Name

I understand that by signing this form, medical photographs may be taken of me or my child (or person for whom I am legal guardian) by the above-mentioned health department for the medical record, teaching purposes and/or for medical publication.

I confirm that this photo release consent has been explained to me in terms I understand, and I will not receive payment from any party for the use of these photos.

At any time, I can revoke this consent by delivering a written and signed statement to the Hansen’s Disease clinic at the Health Department listed above. Revocation or expiration of this authorization does not mean that DSHS will remove these photographs from materials already created while this authorization was in effect. However, DSHS will make every effort to no longer use my photographs in materials created after I revoke this authorization.

Please select the option that applies:

☐ **I consent for my photographs to be used in my medical record. Initials: _____**

Photographs in the medical record will be used by my treatment team to track any changes in my symptoms and document physical findings associated with Hansen’s Disease.

☐ **I consent for my photographs to be used in material designed for teaching purposes and not for commercial use. Initials: _____**

I understand that my personal health information (excluding my name) may be released when using my photographs for teaching purposes. This may include fact sheets posted on the DSHS website for distribution, educational presentations including in-person conferences and webinars for public health audiences, and/or in medical publications that may include medical journals, textbooks and electronic publications. Although these photographs will be used **without** identifying information, I understand that it is possible for someone to recognize me. The images may be seen by members of the public, in addition to healthcare providers, scientists and medical researchers that regularly use this material in their professional education.

☐ **I do NOT authorize any medical photographs to be taken. Initials: _____**

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Health Services

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I understand that the designated health department will not withhold treatment or other benefits if I refuse to sign this authorization.

**Signatures**

**Section I:**

Patient’s Name: ___________________Signature:___________________Date: ___________

Person Authorized to Consent (if not patient):

Relationship:______________________Signature: __________________Date: ___________

**Section II**:

Witness Name/Signature: ______________________________________Date: ___________