COOK COUNTY HEALTH	Category: **CCH SYSTEM WIDE**	
Subject: **Corporate Compliance**	Page **1 of 16**	Policy #: **CC.024.01**
Title: **Filming and/or Recording Safeguarding Privacy Policy**	Approval Date: **3/6/24**	Posting Date: **3/6/24**

PURPOSE

The primary purpose of this policy is to protect and safeguard the privacy and confidentiality of patients, visitors, and Workforce members of Cook County Health (CCH) by providing system-wide information for obtaining consent to film and/or record patients and/or CCH Workforce members. For the purposes of this policy, recording is defined as any images, photographs, motion pictures, videotapes, audio, or computer feeds or recordings whether in digital form or any other medium. The guidance set forth in this policy also outlines how to prevent the improper use of recording of patients, visitors, and CCH Workforce members.

AFFECTED AREAS

This policy applies to all CCH Workforce members, patients, visitors, media, and the general public.

This policy applies to all CCH workforce members, including officers, directors, members of committees with Board-delegated authority, employees, and members of the CCH medical staff or house staff, researchers, students and agency personnel. CCH includes Central Campus *(John H. Stroger, Jr. Hospital of Cook County, Professional Building & Harrison Square)*, Provident Hospital of Cook County, Correctional Health Services of Cook County, Ambulatory & Community Health Network (ACHN), Cook County Department of Public Health (CCDPH), Health Plan Services (this includes CountyCare Medicaid Health Plan and other health plan operations), and any other location where CCH is providing services. This policy also applies to independent contractors, consultants and other business partners who are not employees but are working at/with CCH.

This policy includes patient and treatment areas, clinical areas, and non-treatment areas that may be accessed by patients, visitors, media, and the general public.

Note: Filming and/or recording by individuals affiliated with the media must receive prior approval by the Chief Communications and Marketing Officer, or their designee, and must be facilitated by the Office of Communications. For additional information about informing and responding to media, please see the *HIPAA: Informing and Responding to the Media* policy.

POLICY

Recordings of patients, visitors, workforce, and facilities is limited to those instances that do not violate patient privacy and are compliant with governing federal and state consent/authorization requirements, as well as this policy.

Reason for the policy

Filming and/or recording may impact patient privacy and have the potential to interfere with patient care. This policy intends to ensure that any filming and/or recording is taken, used and/or disclosed in compliance with state and federal laws and in compliance with the accreditation standards of The Joint Commission. In particular, these governing authorities define consent requirements for recording an

individual and/or patient and authorization requirements for certain uses and disclosures of patient information.

Furthermore, this policy intends to establish standards for permissible purposes for recording of any individual (visitor, Workforce members, as well as patients) while at CCH.

Allowable Filming and/or Recording for Business Purposes
Instances Where Patient Consent or Authorization is NOT Required.

A. To document abuse or neglect.
B. For safety or security of patients, Workforce, or visitors.
C. For identification of the patient.
D. By Workforce members involved inpatient care and treatment activities that include patient safety, care coordination, and treatment planning. In such cases, images/video recordings must be integrated into the electronic health record.
E. To monitor clinical condition via video surveillance.
F. For internal educational or teaching purposes in cases where the image has been completely de-identified in accordance with 45 CFR 164.502(d).
G. When legally authorized by law enforcement, law, or court order. Such instances should be brought to the attention of the Office of Corporate Compliance to ensure all required documentation is available before the filming and/or recording occurs.
H. For filming and/or recording done by the patient's family members or friends when the recording does not interfere with patient care or capture other patients or PHI and permission is obtained from any Workforce member being recorded (see also section below).
I. For photography that does not contain any person/patient identifiable information or any associated person/patient identifiable text, the image may be published in textbooks, journals articles, other externally distributed publications or digital media without patient/legally authorized representative authorization.

Other Instances of Filming and/or Recordings Telemedicine

The recording of patient images and sound through telemedicine technology may be accomplished for purposes of treatment without a patient's authorization. Telemedicine recordings will be considered part of the patient's electronic health record and any use of recorded images outside of treatment, payment, or healthcare operations must include the patient's signed authorization. Patients must be provided an explanation of the purposes for the use of telemedicine, the general nature of the equipment to be used, and the security implemented to protect their information at the beginning of the telemedicine appointment. Standard processes in place for general consent for treatment and explanation of patient rights that would exist if the patient encounter was in-person must also exist for telemedicine environments.

Academic and Training Uses

Filming and/or recording that is identifiable may be made for internal use to provide training to students or members of the CCH Workforce with the consent of the patients involved. Disclosure of recordings for academic purposes (such as at conferences, academic presentations etc.) or for training of individuals not part of CCH's Workforce requires the patient sign an authorization describing the disclosure.

Research

Filming and/or recordings to be made for research purposes must be approved by the Institutional Review Board (IRB) and included in the consent/authorization document(s).

Behavioral Health

Filming and/or recordings associated with mental health treatment are subject to additional state and federal regulation. Contact the Office of Corporate Compliance for guidance.

Patient Groups/Patient Meetings

Participants in patient groups and patient meetings must, at a minimum, be informed of the potential for photos or video recordings to be made of the meeting *(Notification, by example but not limited to signage, handouts, and/or announcements to publicize photography or videography is in process, is required. As noted, appropriate consent/authorization may be necessary).* Depending on the use of the filming and/or recordings, additional consent or authorization may be necessary. Contact the Office of Corporate Compliance for guidance. See Attachment D.

Quality Improvement/Quality Assessment (QI/QA)

Filming and/or recordings collected for the purpose of quality assessment or improvement do not require patient authorization under HIPAA but do require consent which is met through the treatment consent signed by patients. Prior to initiating any filming or recording activity, a signed and dated consent must be in the patient's record. Additionally, these images must conform to the minimum necessary information needed for the planned QI/QA activity.

Law Enforcement

A. Disclosure for identification purposes: Recordings may be released in response to a request by law enforcement for the purposes of identifying or locating a suspect, fugitive, material witness, or missing person.

B. Disclosure as evidence of a crime:
   1. Recordings may be released to law enforcement when a CCH Workforce member has been the victim of a crime, and the images are of the suspected perpetrator of the criminal act.
   2. Recordings may be released to law enforcement when the images are believed in good faith to constitute evidence of criminal conduct that occurred on the premises.

C. Mandated reports:
   Recordings may be provided to law enforcement as required by law or in compliance with and as limited by a valid court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer; a grand jury subpoena; or an administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:
   1. The information sought is relevant and material to a legitimate law enforcement inquiry;
   2. The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and
   3. De-identified information could not reasonably be used.

D. Body Cameras. Police body cameras used by local law enforcement must be turned off (deactivated) in locations where a reasonable expectation of privacy exists, such as dressing rooms or restrooms, inpatient floors, and other areas, unless required for capturing evidence; during sensitive exposures of private body parts, unless required for capturing evidence; and/or during the discussion or provision of medical care and exams by medical professionals, unless the patient's behavior creates a serious and imminent threat to the health or safety of a person, the clinical staff, and/or the public.

   For all such instances of law enforcement involvement, contact the Office of Corporate Compliance for guidance before proceeding with releasing any information.

Identification of Individuals in Emergency and Disaster Relief Situations

Recordings may be released to public or private entities authorized by law or charter to assist in disaster relief efforts for notification purposes.

Live Stream

Live stream may be used for purposes otherwise allowable under this policy. For example, live stream of surgical procedures for internal training purposes using institutionally secured devices and transmissions may be performed. Academic streaming to external viewers (ex: academic conferences) and nonacademic streaming (ex: Periscope) may be performed only with institutional approval and with patient consent and authorization.

Marketing/Publicity/Public Relations

Public relations initiatives conducted on behalf of CCH may be performed when the patient has provided prior consent and authorization in accordance with CCH policy on authorization for such public disclosure. Such recordings also must protect the privacy of bystanders by excluding them from recordings made in non-public spaces without the bystander's consent. Bystanders must be given the opportunity to relocate to be out of scope of the recording/photograph.

Social Media

Pursuant to the CCH Social Media and Blogs: Workforce Use and Conduct policy, members of the CCH Workforce may not post recordings that contain PHI to their personal social media accounts. Workforce members are cautioned to consider not only patients in photos but also any PHI visible on white boards, computer screens, documents, etc. that are included in the photo or video recording. CCH sponsored social media use, such as departmental Facebook pages must comply with the requirements described above under marketing/publicity/public relations.

Fundraising

Recordings of patients made for use in fundraising or other development purposes may be taken, used and disclosed only with prior patient consent and authorization.

Events Not Sponsored by the Institution

Events involving CCH Workforce or facilities such as community sponsored health fairs or third-party events honoring CCH staff may include patients at the events. Consideration should be given as to the nature of the event and the extent to which individuals would expect that they may be recorded and the extent of PHI that could be involved. For example, photos taken at a third-party fundraising event

honoring a physician from the institution in which some individuals may be patients of the physician might require different handling from a photo showing an individual receiving a flu shot at a community health fair. The latter requiring a signed authorization whereas the other may not. Event sponsors should be referred to Corporate Compliance to determine when authorization or notice may be needed.

Commercial Uses

Note that conducting for-profit activities in tax-exempt space may impact the institution's tax status.

Recordings made by third parties for the commercial use of the third parties must be approved prior to initiation. Proposed commercial uses should be referred to the Office of the General Counsel.

Use of Patient or Visitor Devices

With prior consent of the involved CCH Workforce members and in accordance with all state and federal regulations and accreditation standards, patients and visitors may use their own devices to record photos or videos only as follows:

A. To record conversations when needed to retain patient instructions with the consent of the treatment provider who is discussing the patient's care.
B. With prior consent of the patient or their legally authorized representative and anyone who will appear in the recording for personal use by the patient or the patient's family and friends.
C. With the prior consent of workforce members or others *(Users may want to further limit those who may be included to the patient and associated guests)* who are to be included in the photo or video recording for personal use by the patient or the patient's family and friends.
D. Photos and video recordings must be obtained in such a way as to minimize capture of information related to other patients such as information on white boards or individuals in waiting rooms.
E. In no case may photos or video recordings be obtained in instances where doing so may interfere with the provision of care or otherwise create an unsafe environment. Care providers are authorized to notify patients or visitors to stop recording in cases where the activity is unsafe or interferes with patient care.
F. CCH Workforce members have the right to refuse recording at any point during the recording.

Personal use of workforce-owned devices

Workforce members wanting to use their own devices for purposes outside their assigned job duties are required to comply with the same requirements as other visitors to the facility.

Recording without authorization or consent is <u>prohibited</u> on CCH premises unless otherwise addressed in this policy.

This includes recording by CCH Workforce for personal use. CCH workforce shall <u>never</u> record patients or visitors for personal use. Recording of patients by other patients, visitors, members of the media, and/or the general public is also prohibited.

DEFINITIONS

A. <u>Authorization.</u> A formal agreement that is completed and signed by the individual that generally allows use and disclosure of PHI for purposes other than treatment, payment, or healthcare operations. See Attachment A.

B. Consent. A formal agreement that is completed and signed or provided orally where allowed by the individual that gives permission for the photograph, video, or audio recordings, and written or transcribed media notes, after being informed of the purpose, methods, benefits, and risks.
C. Live Stream. To transmit or receive live video and audio coverage of an event via the internet.
D. Health Record. A group of records, paper or electronic, maintained by or for a covered entity about individuals and used, in whole or in part, by or for the covered entity to make health care decisions about those individuals.
E. Minimum Necessary. The least amount of protected health information needed to achieve the intended purpose of the use or disclosure in accordance with 45 CFR 164.502(b).
F. Non-treatment Areas. Spaces within CCH facilities that may be accessed by visitors or the general public. For example, a waiting room or the cafeteria are both considered non-treatment areas. However, patients and CCH Workforce members are likely present within these areas, therefore, non-treatment areas are considered patient spaces where there is a reasonable expectation of privacy and filming and/or recording are prohibited without consent or authorization.
G. Patient. Refers to either the patient or his/her properly designated representative.
H. Recording. Any images, photographs, motion pictures, videotapes, audio, or computer feeds or recordings whether in digital form or any other medium.
I. Recording Device. Any equipment other than medical equipment which is used to record images or audio including but not limited to cameras, phones, video recorders, and audio recorders.
J. Security Cameras/Recordings. Recording devices and the associated recordings that are installed and reviewed by security personnel for the purpose of ensuring public safety.
K. Social Media. Websites and applications that enable users to create and share content or to participate in social networking.
L. Staff. See "Workforce" definition below.
M. Telemedicine. The use of medical information exchanged between sites for patient care using two-way video, text, sound or other forms of telecommunications technology.
N. Video Recording. A recording of the visual components of an event that may or may not include accompanying audio components.
O. Visitor. An individual who comes to a CCH facility for reasons other than obtaining personal healthcare. This definition includes the general public.
P. Workforce. Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or business associate, is under the direct control of the covered entity or business associate, whether or not they are paid by the covered entity or business associate.

Note: Also refer to the definitions documented in the CCH Policy: HIPAA Definitions

PROCEDURE/PROCESS

A. Prior to engaging in recording, CCH Workforce members must obtain written consent from the patient when recordings are taken of the patient, any part of the patient's body, the patient's voice, or any part of a procedure that the patient may be undergoing, unless such consent is not required by law (as noted above). See Attachments D and E.

B. If the patient is unable to give written consent and recording is required for clinical purposes, prior consent must be obtained from their designated representative (if available) or from the patient as soon as reasonably possible.

C. Patients and CCH Workforce members have the right to refuse or rescind consent to recording.

D. CCH Workforce members are not permitted to record a patient without the written consent of the patient unless required by law or the recording involves an instance where consent is not required (see above at page 4). Additionally, visitors, members of the media, and/or the general public may not record any person without that individual's verbal permission. See Attachment B.

E. Patients, visitors, members of the media, and/or the general public recording a CCH Workforce member must also obtain permission from that Workforce member and leadership within that area.

F. Recording is not permitted in non-treatment areas accessible to the general public within CCH facilities where patients or CCH Workforce members are present.

G. Any CCH Workforce member recording pursuant to this policy shall use CCH approved equipment. CCH Workforce members are not allowed to record patients or visitors with any personal cell phone or other personal portable electronic device. Recording shall be restricted to only the minimum necessary to achieve the approved purpose. For example, if recording does not require identifiable characteristics of the patient (e.g. their face), the recording should not include such characteristics. Any recording of patients is the property of CCH. See Attachment B.

H. If the patient and/or Workforce member requests that the recording stop, recording should stop after this request.
    1. If recordings are a part of the patient's treatment, the patient's physician should be contacted to address the patient's concerns.
    2. If the recording has been completed with consent prior to the patient's request to stop, then the recording can remain in the electronic health record and be used for treatment and healthcare operations.

I. Unless otherwise authorized by law, recording should not be released to outside requestors without specific written authorization from the patient or his/her designated representative. Written authorization from the patient or his/her designated representative must be obtained by CCH to use recording, taken pursuant to this policy, outside of CCH.

J. Secretly recording any individual is prohibited. Patients, visitors, members of the media, the general public, or CCH Workforce members suspected of this activity must be reported to CCH Police/Security and the Corporate Compliance Hotline (1-866-489-4949).

K. CCH Workforce members who record a patient pursuant to this policy are bound by the *CCH Code of Ethics* and CCH HIPAA Privacy policies to protect the patient's identity and confidential

information. Business Associates are required to abide by the confidentiality provisions set forth in the Business Associate Agreement.

Enforcement

Workforce members are authorized and expected to monitor for recordings and remind violators of CCH policy. Workforce members are authorized to approach visitors, members of the media, the general public, and other CCH Workforce members or others to remind them of the policy and ask that they stop and delete the recordings if the activity is in violation of this policy. Further non-compliance should be reported immediately to the Administrator on Duty/Regional Director and Stroger Campus Police or CCH Security who may ask the violator to delete the image or recording and where appropriate escort the individual from the premises.

Failure to Comply

Violation of this policy by CCH Workforce members will be referred to the appropriate disciplinary processes and subject to disciplinary action up to and including termination or severance of CCH agreement.

CROSS REFERENCES

CCH Personnel Rules
CCH Code of Ethics
Right to Inspect or Copy Electronic Health Records Policy (RC.007.01)
Informing & Responding to the Media Policy (CC.016.01)
Record Retention Policy (CC.022.01),
HIPAA Definitions Policy (CC.009.01)
HIPAA Privacy Management Policy (CC.012.01)

RELEVANT REGULATORY OR OTHER REFERENCES

Health Information Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules
42 CFR §482.13(c)(1)
The Joint Commission Standards (JC RI 2.50)
AHIMA Practice Brief: Patient Photography, Videotaping and Other Imaging

ATTACHMENT(S)/APPENDIX(IES)

Attachment A - Request and Authorization to Release Health Information
Attachment B - Recording by CCH Workforce for Healthcare Operations
Attachment C - Recording by Patients and Visitors
Attachment D – Filming and/or Recording Consent (Non-Procedure)
Attachment E - General Informed Consent to Surgical or Diagnostic Procedure or Invasive Treatment and Anesthesia

POLICY UPDATE SCHEDULE

This policy will be reviewed every three (3) years or in timely response to changes in local, county, state, or federal regulations. Modifications to the procedure will be made as necessary.

POLICY LEAD	Ashley Huntington, JD Privacy Officer, CCH
REVIEWERS	Jeff McCutchan, JD General Counsel, CCH Nicole Almiro, JD Chief Compliance and Privacy Officer, CCH Alexandra Normington Interim Chief Communications and Marketing Officer, CCH
APPROVAL PARTY	Erik Mikaitis, MD Interim, Chief Executive Officer, CCH Electronically Approved

POLICY HISTORY

Written: 07/14/2016 Approved: 07/14/2016 Posted: 07/15/2016
Replaces: JSH # 01.02.09 Photography of Patients, Written: 1997 Sept
Provident # 01.01.12 Consent to Photograph or Electronic Reproduction, Written: 1993

Reviewed/Revised: 2019	Approved: 3/5/20	Posted: 3/5/20
Reviewed/Revised: January 2024	Approved: 3/6/24	Posted: 3/6/24
Reviewed/Revised:	Approved:	Posted:

Attachment A - Request and Authorization to Release Health Information (Page 1 of 2)

REQUEST AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

COOK COUNTY HEALTH

Use this form to request a copy of your medical records. In order for CCHHS to respond promptly and accurately to your Authorization, please complete this form in its entirety.

Patient Last Name	Patient First Name	Patient Middle Name

Birth date Month	Day	Year	Today's Date Month	Day	Year

Address	City	State	Zip	Phone

INFORMATION REQUESTED. I authorize the Cook County Health & Hospitals System to use or disclose the following information during the term of this Authorization. **Check all that apply.**

❑ Clinic visit notes (list Clinic) _____ ❑ Dental records ❑ Emergency Room Report ❑ Surgical (operative report, pathology report) ❑ Summary, including Hospitalization (History and Physical, Consultations, Surgical, Discharge Summary)	❑ Complete Medical Record ❑ Billing Records ❑ X-Ray Results ❑ Laboratory Results ❑ Therapy Notes (please specify) _____ ❑ Other (please specify) _____	**Radiology Images** ❑ General ❑ CT ❑ MRI ❑ Ultrasound ❑ Angiogram ❑ Nuclear Medicine ❑ Bone Scan
❑ Pharmacy Records		
For the following dates of treatment ❑ Specific date: _____		❑ All Dates

From these Facilities (Check all that apply)

❑ John H. Stroger, Jr. Hospital of Cook County ❑ Oak Forest Hospital of Cook County ❑ Provident Hospital of Cook County ❑ Ruth M. Rothstein CORE Center	❑ Cook County Department of Public Health ❑ Ambulatory & Community Health Network ❑ Fantus Clinic ❑ Sengstacke Clinic ❑ Other: _____	**Cermak Health Services of Cook County** ❑ Cook County Jail ❑ Juvenile Temporary Detention Center

RECIPIENT. Delivery details – to you or to the person/company (for example, insurance company, school, physician)

Delivery Method	❑ Pick up in person ❑ US Mail	❑ Other (please specify)

Send To – Name

Address	City	State	Zip	Phone

The purpose of the copy (disclosure) is:	❑ My personal use	❑ Sharing with a healthcare provider	❑ **Other (please specify)**

TERM. Unless a box below is checked, this Authorization will expire when the request is fulfilled.

❑ From the date of this Authorization until: _____

❑ Until the following event occurs: _____

Other (please specify): _____

NOTE: For mental health records, the term must be stated, you may not use "no expiration."

Plate: Black

PATIENT LABEL

Form #0181
Item #28-5000-0181 Form Updated: Nov 20, 2018

Request and Authorization to Release Health Information (Page 2 of 2)

REQUEST AND AUTHORIZATION
TO RELEASE HEALTH INFORMATION

COOK COUNTY HEALTH

Patient Last Name	Patient First Name	Patient Middle Name

SPECIFIC CONSENT SECTION Please note if the below is not completed, this information will not be released.

Check any or all of the boxes below to authorize this information to be used or disclosed with your record.

Information about:

- ❑ A Mental Illness or Developmental Disability
- ❑ HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of these tests were positive or negative)
- ❑ Communicable Diseases
- ❑ Sexually Transmitted Infections
- ❑ Substance (i.e. alcohol or drug) Abuse
- ❑ Abuse of an Adult with a Disability
- ❑ Sexual Assault
- ❑ Child Abuse and Neglect
- ❑ Genetic Testing
- ❑ Artificial Insemination
- ❑ Psychotherapy Notes (which are not part of the official medical record)

❑ **All of the above (By checking this box, I am indicating that I have reviewed the entire list above and authorize the use and disclosure of all related confidential information in the manner described in this Authorization.)**

I understand that I may revoke this authorization at any time by notifying CCHHS in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by CCHHS before receiving my revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that once my health information is disclosed to the recipient CCHHS cannot guarantee that the recipient will not redisclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws.

I understand that CCHHS may require me to sign an authorization prior to receiving research-related treatment or treatment solely for the purpose of creating health information for another party and that CCHHS will not provide such research-related treatment unless I provide this authorization.

I have read and understand the terms of this Authorization and I have had a chance to ask questions about the use and disclosure of the health information. I authorize CCHHS to use or disclose my health information in the manner described in this Authorization.

Signature of Patient	Date
FOR PERSONAL REPRESENTATIVES OF THE PATIENT	
Name of Personal Representative	**Relationship to Patient**
I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.	
Signature of Personal Representative	**Date**

Plate: Black

PATIENT LABEL

Form #0181
Item #28-5000-0181 Form Updated: Nov 20, 2018

Attachment B: RECORDING BY CCH WORKFORCE FOR HEALTHCARE OPERATIONS

A. Recording of a Patient Taken for the Purpose of Healthcare Operations Only.

Written consent must be obtained from a patient for any recordings taken by CCH Workforce members for healthcare operations (for example, quality assurance, training and education). Patients must complete and sign the *Filming and/or Recording Consent (Non-Procedure) FORM* (See Appendix Form 1).

1. If the patient is unable to give written consent at the time of recording:
   - **a.** Consent must be obtained from the patient as soon as reasonably possible after the filming and/or audio recording by having the patient sign the *Filming and/or Recording Consent (Non-Procedure) Form*. If signed after the recording, the consent will be retroactive to the date the recording was taken. OR
   - **b.** Consent must be obtained from their designated representative or from the designated representative as soon as reasonably possible after the recording by having the designated representative sign the *Filming and/or Recording Consent (Non-Procedure) Form*. If signed after the recording, the consent will be retroactive to the date the recording was taken.
2. If written consent is not obtained, any recording taken shall be securely destroyed.
   - **a.** Once written consent is provided, recording for operational purposes can be used for internal or external activities consistent with the missions of CCH, such as education and research, conducted in accordance with CCH's policies.
   - **b.** Recording taken for the patient's treatment should be stored securely to protect confidentiality and also incorporated into the patient's electronic health record. (Refer to section C, "Ownership, Storage and Retention of filming and/or recording" within this appendix.)
   - **c.** Where the CCH Maternal Child Division films newborns to provide as a keepsake to new parents, a Filming and/or Recording Consent (Non-Procedure) Form must be signed and scanned into the newborn electronic health record.
   - **d.**

B. Withdrawal of Patient Consent/Patient Requests to Cease Recording.

1. CCH Workforce members shall not record after a patient or their designated representative requests that any type of recording stop or if the consent is revoked.
2. Even after a patient signs the *Filming and/or Recording Consent (Non-Procedure) Form*, the patient may revoke the authorization and the recording will not be used to the extent that authorization has not been relied upon.

C. Ownership, Storage and Retention of Images and/or Recording.

1. Images and/or recordings should be clearly identified with the patient's name, identification number and date and stored securely to protect confidentiality.
2. Where images and/or recordings are used to document patient care, these images should be kept in accordance with the State and Federal document retention requirements as well as stored within the patient's electronic health record. *See CCH Record Retention policy.*

D. Failure to Comply

Failure to comply with this policy may result in disciplinary action up to and including termination. Please see the *CCH Personnel Rules* for further details.

Attachment C: RECORDING BY PATIENTS, VISITORS, AND MEMBERS OF THE MEDIA

Recording by Patients or Visitors.

1. Recording of CCH Workforce members including physicians, staff members, volunteers, contractors, are not allowed to be taken without that individual's permission.
   a. If CCH Workforce members have questions about providing consent for recording, he or she should consult with the CCH Risk Management Office or the Office of Corporate Compliance before any consent is given or recording.
   b. If consent was given by the CCH Workforce member, they have the right to revoke the consent immediately after conclusion of recording.
2. Recording of medical equipment or devices are not allowed (excluding tubes attached to the patient) unless the request to record the medical equipment or device is for a business purpose and has been approved by CCH Supply Chain Management.
3. Patients, visitors, and/or members of the media are not allowed to record other individuals in non-treatment areas of CCH premises, such as cafeteria or waiting areas.
4. In the event that CCH Workforce members become aware that a patient, visitor, or member of the media films and/or records in violation of this policy, the following steps should be taken and CCH Risk Management and the Office of Corporate Compliance should be consulted:
   a. CCH Workforce members present should instruct the patient, visitor, or member of the media to immediately stop recording. If the individual refuses or does not cooperate, CCH Police/Security should be contacted.
   b. If proper permission was not obtained, CCH Police/Security may ask the patient, visitor, or member of the media to delete the recording.
   c. CCH Police/Security or CCH Workforce will not access the contents of devices or force deletion of any contents. CCH may choose to take legal action against patients, visitors, or members of the media that violate this policy.

Attachment D – FILMING AND/OR RECORDING CONSENT (NON-PROCEDURE)

COOK COUNTY HEALTH

FILMING AND/OR RECORDING CONSENT (NON-PROCEDURE)

Patient Last Name			Patient First Name		Patient Middle Name		
Medical Record Number							
Birth Date	Month	Day	Year	Today's Date	Month	Day	Year
Address			City	State	Zip	Phone	

I consent to allowing filming and/or recordings to be used by CCH for teaching, medical education and research purposes, including release within the hospital system to individuals, to groups, and to the general public. I hereby authorize the modification of retouching of such photographs and waive any right to inspect or approve the finished product as it may appear to be used.

- ❑ Use in connection with medical research and education.
- ❑ Use by CCH for public relations and/or advertising purposes.
- ❑ As a courtesy to me per my request.
- ❑ Other purposes (specify below):

Signature of Patient	**Date**

FOR AUTHORIZED REPRESENTATIVES OF THE PATIENT

Name of Authorized Representative	Relationship to Patient

I hereby certify that I have the legal authority under applicable law to grant this authorization and make this request on behalf of the patient identified above.

Signature of Personal Representative	**Date**

Form Updated: January 2019 Page 1

Attachment E - GENERAL INFORMED CONSENT TO SURGICAL OR DIAGNOSTIC PROCEDURE OR INVASIVE TREATMENT AND ANESTHESIA (Page 1 of 2)

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

John H. Stroger, Jr. Hospital of Cook County
1901 W. Harrison Street
Chicago, Illinois 60612

GENERAL INFORMED CONSENT TO SURGICAL OR DIAGNOSTIC PROCEDURE OR INVASIVE TREATMENT AND ANESTHESIA
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1. I, _____, hereby authorize the following designated physician(s): _____ and/or such assistants as may be selected by the above designated physician (s) to perform the following surgical or diagnostic procedure or treatment (hereafter known simply as the "procedure") upon myself/the patient or for the patient for whom I am the legal guardian or for whom I have power of Attorney for Health Care decisions: I authorize other members of the health care delivery team designated by the above physician (s) to be present in the operating room.

NAME OF PATIENT:_____

PROCEDURE:_____

2. SUMMARY OF INFORMATION

I acknowledge that I have been provided with and considered and understand the following information:
A description of the proposed advised procedure and the medical reasons and the reasonable benefits why the proposed procedure and anesthesia is advisable;

- All procedures have risk. Most risks and complications are relatively uncommon while some are very rare but severe. Overall, the procedure is advised because in your physician's best judgment, the medical benefits outweigh the risks and complications. The typical known risks and complications of the advised procedure are, including but not limited to possible: BLEEDING, INFECTION, PAIN, SCARRING, NERVE INJURY, FAILED SURGERY, REOPERATION, AND DEATH;
- Case specific additional typical known risks and complications including but not limited to: _____ _____ _____;
- The goals of the advised procedure and the general likelihood of achieving these goals;
- The reasonable alternatives to the advised procedure, including declining the procedure and doing no procedure, the expected reasonable benefits, typical known risks and complications of the reasonable alternatives or of doing no procedure;
- No promises or guarantees of success or outcome have been made.

3. ADDITIONAL AND DIFFERENT PROCEDURE

I have been advised that during the course of this procedure or immediately thereafter, conditions that are not presently known may be revealed making it necessary to perform additional or different procedure(s) or treatment(s) than are described above. I therefore authorize and request that the above-named physician(s) and assistant(s) perform such additional or different procedure(s) or treatment(s) as they deem necessary or advisable in their professional judgment for the welfare of the patient.

4. ALLERGIES

I have informed the licensed health care provider that, to my knowledge, I have **allergies** to the following substances and drugs:_____

5. PHOTOGRAPHING, FILMING AND/OR TELEVISING AND THE RE-PUBLICATION

I consent to **photographing, filming and or televising and the re-publication** with respect to the procedure and related medical information about me/the patient, including appropriate portions of my/the patient's body, for medical, scientific, or educational purposes, provided my/the patient's identity is not revealed by the information, images or the descriptive texts accompanying them.

_____**INITIAL HERE IF REFUSING PHOTOGRAPHING, FILMING AND/OR TELEVISING AND THE RE-PUBLICATION**

6. ADMINISTRATION OF BLOOD AND BLOOD PRODUCTS

I have authorized the **administration of blood and blood products** to myself/the patient and have signed the (separate) consent form for blood transfusions.

____ **INITIAL HERE IF REFUSING BLOOD AND BLOOD PRODUCTS**

7. OBSERVERS

For the purposes of advancing medical education, I consent to the admittance of **observers,** approved by my physician, other than members of the health care delivery team, to the room in which the procedure is performed.

____**INITIAL HERE IF REFUSING OBSERVERS OTHER THAN MEMBERS OF THE HEALTH CARE DELIVERY TEAM**

8. EVALUATION AND DISPOSAL OF TISSUE AND USE OF TISSUE FOR RESEARCH PURPOSES

Removed tissue or body parts shall receive a medically indicated pathological evaluation. I consent to the **use of tissue or body parts for research purposes and for the disposal** by Hospital of any tissues or body parts removed by the procedure.

_____**INITIAL HERE IF REFUSING USE OF TISSUE OR BODY PARTS FOR RESEARCH PURPOSES**

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Do Not Write Below This Line

PATIENT LABEL

General informed Consent to Surgical or Diagnostic Procedure or Invasive Treatment and Anesthesia. Page 2 of 2)

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

John H. Stroger, Jr. Hospital of Cook County
1901 W. Harrison Street
Chicago, Illinois 60612

GENERAL INFORMED CONSENT TO SURGICAL OR DIAGNOSTIC PROCEDURE OR INVASIVE TREATMENT AND ANESTHESIA
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9. PATIENT CONSENT

I acknowledge that I fully understand this document and have had the opportunity to have any questions answered by the physician/health care professional. I acknowledge that I have received no promises or guarantees with respect to the benefits to be realized or outcome of the procedure or treatment. I understand the information provided and give this consent voluntarily.

PATIENT SIGNATURE*: _____/_____ Date: _____ Time: _____
(Patient or authorized decision maker) relationship

***If person giving consent is an authorized decision maker and not the patient, complete the following:**
_____ Patient named above is a minor *OR*
_____ Patient lacks decisional capacity as certified by the attending physician in the medical record

10. PHYSICIAN *OR* LICENSED HEALTH CARE PROFESSIONAL (LHCP)

The signee attests that he or she discussed the procedure in person or via telephone with patient or authorized decision maker OR If the procedure is emergent as documented in the medical record and the patient or authorized decision maker is unable to give consent, two physician signatures are required.

PHYSICIAN OR LHCP SIGNATURE: _____ Date: _____Time:_____
Print name_____

SPECIAL SITUATIONS:

EMERGENCY PROCEDURES: A second physician is required to sign if the procedure is emergent and the patient or authorized decision maker unable to give consent.
2ND PHYSICIAN SIGNATURE:_____ Date: _____Time:_____
Print name_____

TELEPHONE CONSENT: If consent is obtained over the telephone, a witness is required.
Print name and telephone number of authorized decision maker on the patient signature line above.
SIGNATURE OF WITNESS: _____ Date: _____ Time: _____
Print name: _____

11. ADMINISTRATION OF ANESTHESIA

I authorize the administration to myself/ the patient of anesthetics including administration of all medications for LOCAL/REGIONAL/SPINAL/EPIDURAL / SEDATION / GENERAL/ or other available means of anesthesia of such type, combination and method(s) as are determined to be necessary or advisable by the physician responsible for administering or supervising the administration of anesthetics. I acknowledge that I have been advised about, and understand, the nature and purposes of advised anesthesia and reasonable alternative anesthesia methods and post operative pain management, as well as the reasonable benefits, typical known risks, complications and side effects of advised anesthesia and reasonable alternative anesthesia.

PATIENT SIGNATURE: _____ Date: _____ Time: _____
Physician/CRNA: _____ Date: _____ Time: _____
Print name: _____

12. ANESTHESIOLOGIST ATTENDING AFFIRMATION (required only if Anesthesia Service is involved)

I affirm that I have, by verbal explanation and, if applicable, by other methods of communication such as written information or pictures, provided to the patient and/or the authorized decision maker the information contained in paragraph 11 above.

ATTENDING ANESTHESIOLOGIST: _____ Date: _____ Time: _____
Print name: _____

13. INTERPRETER

I have interpreted this consent form into (_____) which is the language understood by the patient or authorized decision maker. Please indicate who assisted with interpretation:

☐ CCHHS Interpreter ☐ CCHHS Remote ☐ Non-CCHHS Remote Interpreter

INTERPRETER SIGNATURE: _____
Date: _____ Time: _____
Print name: _____
CCHHS Remote Interpreter: _____
ID number: _____
Non-CCHHS Remote
Interpreter Provider: _____
ID number: _____

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PATIENT LABEL