Texas Children's®

Art Therapy Authorization

Please print:
I hereby authorize the artwork/art therapy imagery of_____ (insert patient name) to be used, displayed, videotaped, or photographed by the art therapist and/or Texas Children's Art Therapy Program for the following purpose(s):

Scope of use:

- ☐ Exhibition
- ☐ Media/Public Relations
- ☐ Marketing/Promotional Materials
- ☐ Educational Purposes
- ☐ Professional Publications, including print and online
- ☐ Website and other interactive communications
- ☐ Professional Presentations/Conferences
- ☐ Community outreach or advocacy
- ☐ Consultation with other mental health professionals
- ☐ Research Purposes
- ☐ Fundraising/Development

Please read the following and indicate your authorization by signing below.

- I hereby authorize the above-mentioned therapist/program/organization to use, display, photograph, and/or videotape (including film photography, digital photography, cinematography and videographer) the patient artwork named above. I understand that photographs and films of the artwork may be taken individually or as part of a group display.
- I understand that in authorizing use of patient artwork, I am potentially disclosing information about the patient's health depending on how the artwork and/or video or photo is used by the therapist/program/organization. I understand that once this information is disclosed, it may be redisclosed by those who view it and no longer subject to the protections under HIPAA.
- I waive any right of inspection or approval of the patient artwork's appearance, patient information, or the uses to which that appearance or information may be put.
- I understand that once the news media interviews and/or photographs the patient artwork, the media owns all rights to that footage and Texas Children's has no authority over where or when it is displayed. The footage can be used how the news media sees fit throughout the world in perpetuity.
- I understand that patient artwork will be safeguarded to the best ability of the art therapist. I hereby release Texas Children's and its entities from any claim for damages including, but not limited to, breach of confidentiality, invasion of privacy, violation of the therapist-patient privilege, or violation of any state or federal law.
- I understand that Texas Children's will not condition treatment or payment on my completion of this form.
- I understand that at any time, I am entitled to revoke this authorization by completing a Revocation of Authorization form. If this authorization is revoked, the revocation will not apply to previous uses made in good faith under this authorization.

Restrictions on use or disclosure of information:

☐ I prefer to remain anonymous in the above-authorized uses of my artwork/art therapy imagery by the art therapist, Texas Children's Art Therapy Program, and/or Texas Children's.

I allow _____ (art therapist/Texas Children's) to disclose protected heath information about condition, diagnosis, or treatment for which he/she is providing the treatment. But, I do not allow them to discuss:

_____

Patient/Artist name: _____ Patient/Artist birth date: _____

Signature: _____ Printed name: _____
Patient, Parent or Legal Representative

Relationship to Patient/Artist: _____

Address: _____
Number and Street

_____
City, State and Zip Code

Phone number: _____ E-mail address: _____

Witness: _____Date: _____

Questions? Ask a Texas Children's representative.

Employee obtaining authorization (Name, Employee ID, and Department):_____

For internal use only – please print.* ***The patient/patient's legal representative must be provided with a copy of this form.*