County of Los Angeles **Department of Health Services**

OLIVE VIEW-UCLA MEDICAL CENTER
RESPIRATORY CARE SERVICES – SLEEP MEDICINE
POLICY & PROCEDURE

NUMBER: 5860
VERSION: 1

SUBJECT/TITLE: CONSENT FOR POLYSOMNOGRAPHY

POLICY: Patients will sign consent to a photograph, and recording of audio/video.

PURPOSE: PERMISSION TO PHOTOGRAPH AND/OR RECORD AUDIO AND VIDEO

DEPARTMENTS: RESPIRATORY CARE SERVICES

DEFINITIONS:

PROCEDURE:

I, _____,
Patient/Guardian

hereby authorize, OVMC Sleep Medicine Center, Sleep Laboratory, to take photograph(s) and/or record audio and video during the scheduled sleep testing

of _____.
Name of Patient

I understand that such photograph(s), audio recording(s) and/or video recordings may be used for clinical or educational purposes or in the event of legal action. The Olive View Sleep Medicine Center and OV-UCLA Medical Center are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s) and/or video recordings.

The undersigned also hereby transfers and assigns to the OV-UCLA Medical Center the right to copy the materials in whole or in part. No use of the material for educational purposes will identify me by name.

Check here if you do NOT authorize use for educational purposes.

_____ _____
Signature (patient or guardian) Date

Relationship to Patient if Guardian
_____

References:	
Approved by: Jeanne Wallace (Division Chief)	Date: 07/10/2018
Review Date: 07/10/201807/10/2021	Revision Date:
Next Review Date: 07/10/2021	
Distribution: Respiratory Care	
Original Date: Not Set	