

JEFF PODIATRY

CONSENT FOR PHOTOGRAPHIC DOCUMENTATION OF CARE

"I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that JEFF PODIATRY will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in JEFF PODIATRY's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative."

Patient Name: _____ Patient Date of Birth: _____

Patient Signature: _____ Date: _____

Note: This consent does not authorize the use of the images for other purposes, such as teaching or publicity. A separate consent for photography form should be used for such purposes.

Source: American Health Information Management Association (AHIMA) Practice Brief: Patient Photography, Videotaping, and Other Imaging (Updated).