Medical Records Photo Consent

R10/20/20

I consent to be photographed for my medical record and authorize the use and disclosure of the photograph for the following uses and purpose of identification in medical record, dissemination to providers, agency personnel and other involved in my healthcare.

I understand my photograph will only be used as part of my medical record for patient identification purposes and will not be used or disclosed to external entities/persons without my written consent.

I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I hold harmless the agency, its employees and medical providers participating in my care against any claim for injury or compensation resulting from the activities authorized by this consent.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____

Staff Signature: _____ Date: _____