Gateway Medical

Photo Release Form

AUTHORIZATION AND CONSENT FOR TAKING PICTURES TO ENABLE CLINICAL STAFF TO ASSESS WOUNDS, RECORD A VISUAL IMAGE AND MONITOR THE HEALING PROCESS

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Patient ID:** _____

Gateway Medical understands that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may take a picture for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

You or your personal representative should carefully read the descriptions below before signing this form.

Gateway staff may take photos to document medical progress and transmit them for the use of clinical care. Documenting images will be used to support patient treatment. Gateway staff will have explained the need to take a picture. Images may be placed in medical record, electronically shared to the clinical team or to the treating health professional.

Your health information will be received and used only by Gateway staff, representatives, designees or affiliated company or agent thereof.

You have the right to change your mind, even after signing this form. Please contact Gateway staff in the event you wish to revoke consent after providing authorization.

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you agree to have photos taken and transmitted when medically appropriate. You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form. You also have a right to receive a copy of this form after you have signed it.

SIGNATURE

*I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above***:**

_____	_____	_____	_____
Signature of Patient or Personal Representative	Date	Signature of Witness	Date
_____	_____	_____	_____
Print Name of Patient/Personal Representative	Date	Print Name of Witness	Date

CONTACT INFORMATION

The contact information for the patient or personal representative who signed this form should be filled-in below:

_____	_____	_____
Street Address	City/State/Zip	Daytime Phone
_____	_____	_____
Street Address	City/State/Zip	Evening Phone