DERMATOLOGY ASSOCIATES of York, Inc.

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

PATIENT NAME: _____ **ACCT#** _____

During your visit(s) at Dermatology Associates of York your healthcare provider may find it helpful in managing your care to photo-document the specific location and appearance of your condition or clinical findings. The purpose of medical photography is to document findings, care, and treatment progress. The images will remain solely in your medical chart and treated as any other part of your medical record. They will be protected and handled in accordance with applicable HIPAA privacy regulations.

The medical photographs will not be used for any purpose other than your care and treatment without your express written consent. You may refuse to have photographs taken at any time.

I have been provided the opportunity to ask questions concerning the information contained in this consent. By signing below, **I consent to medical photography** during the course of my care and treatment.

_____ _____

Signature of Patient or Authorized Representative Date

Printed Name of Authorized Representative:_____

Relationship of Authorized Representative: _____

Note: The section below is only to be completed if patient refuses

REFUSAL:

I **refuse** to have medical photographs taken during my care and treatment.

_____ _____

Signature of Patient or Authorized Representative Date

Printed Name of Authorized Representative:_____

Relationship of Authorized Representative: _____