pfrankMD™

CONSENT TO MEDICAL PHOTOGRAPHY

Patient Name: _____ DOB: _____

Given the aesthetic nature of our practice it is imperative to keep photographic as well as written records of your skin to assist with treatment and follow up. It is performed to ensure our safety and efficacy standards are met. The photos will be used to record the progress of procedures performed and their results. Photographs will form part of your official medical record which are protected by Federal HIPAA Privacy Laws. The details of HIPAA were given for your review upon your initial consultation with our practice. They can be reviewed at any time at your request.
As with any part of your medical record, only authorized personnel in our practice involved in your care can view these records. They are most often used between the patient and the physician for comparison study.

Photographs will only be taken and used with your consent, which can be refused or limited by you and you can also withdraw this or change it in the future.

____I consent to photographs being taken for my medical records throughout my care

____ I do not consent to photographs being taken. I understand that the appropriate comparison for evaluating results, progress or complications cannot be assessed or accounted for without them, therefore limiting the treatment options available including but not limiting to touch ups and revisions.

I acknowledge that under no circumstances are patient submitted photographs (ie 'selfies') submissible as medical evidence or recordings given their lack of standardization and editability.

Signature: _____(Patient) Date: _____

Signature: _____(Parent/Guardian/Carer)

Witness: _____