ARCHANGEL MICHAEL HEALTH, PA

Consent for Photography / Video Recording

Phone: (352) 441-9110 | Fax: (352) 441-9114

1. Patient Information

Name:

Date of Birth (MM/DD/YYYY):

Address:

City, State, ZIP:

2. Purpose of Photos / Videos

> Archangel Michael Health, PA may capture photographs or video recordings of patients for the sole purpose of documenting clinical findings, tracking progress, or assisting in medical decision-making. These images will become part of the secure patient medical record.

3. Patient Verbal Consent Requirement

Direct Verbal Consent: We will never take photographs or videos without first obtaining direct, explicit verbal consent from you (the patient) at the time the photo or video is taken.

Right to Decline: You have the right to decline photography or video recording at any time. Declining this consent will not impact your ability to receive care.

4. Data Security & Storage

- **HIPAA-Compliant Devices/Software:** Any photo or video will be captured on an encrypted device or through HIPAA-compliant software/platform.
- **Transfer to Patient Chart:** The images will be transferred directly into your secure patient chart in our HIPAA-compliant system.
- **Deletion Within 24 Hours:** All images/videos will be deleted from the recording device or temporary storage location within 24 hours of capture.

5. Confidentiality & Usage

- **Confidentiality:** The photos/videos will not be shared with individuals outside of your care team, except as required by law or with your explicit written authorization.
- **Clinical Use Only:** These images are used strictly for treatment-related purposes such as diagnosis, care planning, or medical education within Archangel Michael Health, PA. They will not be used for marketing, social media, or other non-clinical purposes without separate written consent.

6. Rights & Revocation

- **Right to Withdraw:** You may withdraw this consent at any time in writing. This will not affect any photographs or recordings taken prior to the withdrawal date.
- **Access to Images:** You may request to view or obtain a copy of any photographs or videos in your medical record, subject to standard request procedures and fees (if applicable).

7. Acknowledgment & Signature

I have read (or have had read to me) and understand the above information regarding consent for photography or video recording. I am aware that:

1. Images will be stored in my secure patient chart and removed from devices within 24 hours.
2. Images will not be taken without my direct verbal consent at the time of capture.
3. I can refuse photography or video without compromising my care.
4. I can revoke this consent at any time in writing.

Patient/Legal Representative Signature:

_____

Printed Name:

_____

Date (MM/DD/YYYY):

_____

Relationship to Patient (if applicable):

_____

Attach documentation of legal authority if signed by someone other than the patient.

Thank you for trusting Archangel Michael Health, PA with your healthcare needs.

If you have any questions or concerns about this form or the process of photography/video recording, please contact our office:

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