pediatric dermatology OF MIAMI

Authorization for Release and Use of Photographs

Patient's Name _____ DOB_____

Photographs (including digital images) will be taken for treatment and documentation purposes. Photographs will become part of the medical record in the patient's chart and will be handled in accordance with the Health Insurance Portability and Accounting Act of 1996 (HIPAA). In addition, the undersigned grants to the treating physician the on-going and unrestricted right to use the photographs (but not the patients name) in the ways indicated below.

Your Identity/personal information will never be revealed.

Please initial consent (yes) or non-consent (no) for each specified

Yes_____ No_____ For medical research, education or science (including medical seminars or journal articles)?

Yes_____ No_____ For use during in office patient consultations?

_____ _____

Patient Signature Date