New England Wound Care, LLC

AUTHORIZATION TO INTERVIEW, PHOTOGRAPH, OR VIDEOTAPE FOR DIRECT PATIENT CARE

I hereby grant New England Wound Care, LLC permission to make video and/or audio recordings as well as still and/or motion photography of me. I understand that these photographs or recordings may be used as part of my treatment.

It has been explained to me that these photographs or recordings shall be made by designated staff of New England Wound Care, LLC and that still photographs may become a permanent part of my medical record.

I understand that images that are not a permanent part of my medical record will be stored in a secure manner that will protect my privacy for a period of ___ years. I have been advised that these documents or images will be destroyed after the retention period.

I understand that I will be asked to sign a separate authorization if any images that identify me are to be used for purposes other than medical treatment.

I also understand that any of these materials that are incorporated into my medical record can only be released to persons outside of New England Wound Care, LLC based on my written authorization.

I am satisfied with the explanation that has been provided to me as to the use of these photographs or recordings. This Authorization to interview, photograph or videotape will expire on _____.

Signature: X_____ Date: _____
(or Authorized Representative)

Witness: _____ Date: _____

Photographer/
Technician: _____ Date: _____