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# Authorization for Release/Use of Protected Health Information In Photograph/Videotape/Electronic Images From Medical Record for Education Training

I, _____, hereby give permission to NYOTA MEDICAL FOOTCARE, PLLC to make a photograph, videotape, or other electronic recording ("recording") of me during the course of my treatment. I am at least 18 years of age. Those recordings will become part of the medical record in the patient chart. Under the Health Insurance Portability and Accounting Act of 1996 (HIPAA), those recordings may be supplied as part of the medical records to medical specialty boards and hospital medical staffs reviewing the treating physician's credentials. I grant the on-going and unrestricted right to use those recordings (but not my name) for purposes, including but not limited to:

- Use by medical specialty board in formulating its examination of applicant physicians
- Medical research, education, or science
- Professional medical journals, videos, or books
- Supervision or education purposes
- Inclusion in the Department's private educational videotape and recordings library, access to which is limited to Department faculty, staff, and authorized trainees

I acknowledge that the persons to whom the recordings may be disclosed for the above purposes include but are not limited to other practicing physicians, medical/nursing students, residents and other health care trainees, health care providers, and their staff. Under HIPAA, if the organization or person authorized to access the recordings is not a health plan or health care provider, the released information may not be covered by HIPAA's protections from further disclosures or use by federal privacy regulations.

I understand that:

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON-COMMUNICABLE DISEASE.

I may refuse to sign this Authorization and it is strictly voluntary. My treatment or regular care is not conditioned upon my signing this Authorization. I may revoke this Authorization at any time in writing at any time.

Patient signature/Legal Representative: _____Dated: _____

Name of Legal Representative:_____