

# CONSENT TO PHOTOGRAPH

*This form is to be used only for photographs taken for treatment or the hospital's own health care operations. Photography for other purposes (e.g., research, publication, outside education, marketing, public relations, news or documentary) requires use of the form "Consent to Photograph and Authorization for Use and Disclosure (CHA Form 24-4).*

The undersigned hereby consents to be photographed while receiving treatment at the hospital, with the understanding that the images from such photography may be used for my treatment or for hospital health care operations such as peer review or medical education, as the hospital or my treating physician(s) deem appropriate, and that such use is subject only to the following limitations:

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The term "photograph" as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(patient/parent/guardian)

If signed by other than patient, indicate relationship: \_\_\_\_\_

Witness: \_\_\_\_\_

Original: Medical Record

Copy: Patient

# CONSENTIMIENTO PARA TOMAR FOTOGRAFÍAS

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Por este medio, yo, el suscrito, autorizo para que me tomen fotografías mientras recibo tratamiento en el hospital, con el entendimiento que las imágenes de dichas fotografías se pueden utilizar para mi tratamiento o para operaciones de atención médica propias del hospital, tales como revisión entre colegas o educación médica, de acuerdo con lo que el hospital y el o los médicos que me traten consideren conveniente, y que dicho uso está sujeto únicamente a las siguientes limitaciones: \_\_\_\_\_

El término "fotografía", según se usa en la presente, incluye fotografía estática o en video, en formato digital o en cualquier otro formato, así como cualquier otro medio de grabar y reproducir imágenes.

Fecha: \_\_\_\_\_ Hora: \_\_\_\_\_ am / pm

Firma: \_\_\_\_\_  
(paciente/padre/madre/tutor)

Si firma un tercero y no el paciente, indique la relación: \_\_\_\_\_

Testigo: \_\_\_\_\_

Original: Expediente médico

Copia: Paciente

Original: Medical Record

Copy: Patient

