



Monday, June 19, 2023

Consent For for Photography, Video, and/or Audio Recordings Medical Record Only

During my course of treatment at with Dr. Schwartz & Staff, my voice, photographs, and/or video may be taken or recorded (collectively "the materials"). I understand that by signing this document, I give permission for Dr. Schwartz & Staff to copyright and/or use these materials in my medical records. Refusal to consent to photographs will in no way affect the medical care I receive.

By signing this form below, I confirm that this consent has been explained to me in terms I understand. This consent serves to waive all rights of privacy or compensation which I may have in connection with the use these materials. I will have no claim on ground of breach of confidence or on any ground in any legal system against Dr. Schwartz & Staff. At my request, I can have access to view the materials or obtain copies, but I must notify Dr. Schwartz & Staff in writing if I no longer wish these materials to be used for the purposes granted by this consent form. I understand that these materials will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law. After which, Dr. Schwartz & Staff will not permit the further release of these materials, but will not be able to call back any of the materials or information already released.

I grant permission for :

- Use in my medical records, including, but not limited to, dissemination to other medical staff or physicians.

If the patient is under the age of 18, a parent or guardian should give consent.

Name

Niza Aguilar

Patient Signature:

Date:

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