PATIENT CONSENT FORM

The department of health and Human Services has established a "Privacy Rule." The Privacy Rule was created in order to provide a standard for certain health care providers to obtain their patients' consent for user and disclosures of health information.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We may wish to take photos of you while in our clinic for treatment, educational, and/or advertising purposes. However prior to using any photographs for advertising purposes we will obtain consent from the patient, parent, or legal guardian.

You may refuse consent to the use or disclosure of your personal health information, but this must be in writing. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form. Please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

INFORMED CONSENT TO PHOTOGRAPH

Date: _____

I, _____, due hereby give consent for Dr. Jose Francisco De Leon or staff to take and/or display photograph(s) and or baby. The photograph(s) will be used for educational and/or advertising purposes by Jose Francisco De Leon, M.D. and may be displayed within our office and/or on the practice's webpage, www.doctordeleon.com. The doctors and office staff will protect your personal data, such as name, age and date of birth, from being displayed.

Print Name: _____ Signature _____

Relation to Patient:

_____Self _____Guardian Witness _____