5Star
Home Care, LLC

Consent for Photographs

Patient Name: _____ MR#: _____

I, _____, hereby grant permission to Agency to take photograph(s) of _____ (please specify area) _____.

I understand that the use of these photographs are for documentation purposes as per Agency's policy as well as for decision making purposes in developing my Plan of Care. I further grant **the Agency the right to give, transfer, and/or exhibit the photographs as per Patient Service Agreement.**

_____ _____
Patient Signature Date

_____ _____
Patient Representative Signature Date
(if patient unable to sign)

_____ _____
Witness Signature Date

Consentimiento Para Tomar Fotografias

Nombre del paciente: _____ MR#: _____

Yo, _____ concedo permiso a la Agencia para tomar fotografia(s) _____ (por favor especifique el area) _____.

Entiendo que estas fotos seran usadas para la documentacion que se requiere de acueredo a la poliza de la Agencia y tambien para ayudar a formular mi Plan de Tratamiento. Concedo a **la Agencia el derecho de entregar, transferir y/o exhibirlas de acuerdo con el Convenio de Servicio al cliente.**

_____ _____
Firma del Paciente Fecha

_____ _____
Firma del Representante del Paciente Fecha
(Si el paciente no puede firmar)

_____ _____
Firma del tesitgo Fecha

ADVANCE HOME CARE
INCORPORATED

"CONSENT FOR PHOTOGRAPHS"

PHOTOGRAPHIC WOUND DOCUMENTATION

PHOTOGRAPHY PERMISSION
I understand and authorize photographs of myself to be taken and kept on file at the Agency. These photographs will be used as deemed appropriate by the Agency.

PERMISO PARA FOTOGRAFIAR
Yo entiendo y autorizo a que se me tomen fotos y se mantengan archivadas y serán usadas apropiadamente por la agencia.

Signature _____ Date _____

_____
WITNESS/SN SIGNATURE

Alexa Home Health Care, Inc.

PATIENT RELEASE TO PHOTOGRAPH

PERMISO PARA FOTOGRAFIAS

I understand, hereby grant Alexa Home Health Care, Inc., and their representative, _____, permission to take photographs of me and to use the finished photographs in any legitimate ways they deem proper.

Further, I relinquish and give to Alexa Home Health Care, Inc., all rights, title and interest I may have in the finished pictures, negatives, reproductions and copies of the original prints and negatives.

I also grant the right to give transfer and exhibit the negatives, original prints, or copies and facsimiles, mail, delivery, thereof to any responsible individual, business Firm, or Publication , or to any of their assignees, following all privacy requirements, and HIPAA regulations.

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*Yo entiendo, y de esta forma autorizo a **Alexa Home Health Care, Inc.**, y sus representantes: _____ , a tomar fotografias mias y usar dichas fotografias en una forma legítima que sea requerida.*

*Ademas, yo declino y doy a **Alexa Home Health Care, Inc.**, todos los derechos, titulos, intereses que yo pueda tener sobre dichas fotografias, negativos, reproducciones y copias de los originales o negativos.*

Yo además doy los derechos de transferir, exibir los negativos, originales, o copias, y de poder faxear, enviar por correo, o personalmente a cualquier persona responsable, Firma Comercial, o Publicacion, o a cualquiera de sus asignados, cumpliendo con todos los requisitos de privacidad, y regulaciones de HIPAA.

Signature of Patient *(Firma)*: _____ **Date:**_____
Fecha

Witness:_____ **Date:**_____
Testigo *Fecha*

AllAround Home Health Agency, Inc.

CONSENT TO PHOTOGRAPHS

Patient Name: _____ MR#- _____

I, _____
Patient / Parent representative.

Hereby authorize All Around Home Health Agency, Inc. to take photographs of

_____
Location

I understand that them photographs will be retained in my clinical records, and are subject to the agency's confidentiality policies and procedures and will be released only to those entities identified on the initial consent to treatment form previously signed by me. This consent is titled Consent to Treatment, Release of information, and Statement to Permit the Payment for Home health Services or Hospital Insurance or medical Insurance Benefits to All Around Home Health Agency, Inc.

_____ _____
Signature of Patient or Patient Representative Date

_____ _____
Signature of Witness Date

CONCENTIMIENTO PARA FOTOGRAFIAS

Nombre del Paciente: _____ Historia Clinica. #: _____

Yo: _____
Paciente / Resentante del Paciente

Mediante la presente autorizo a All Around Home Health Agency, Inc. a tomarme fotograflas de mi o mis:

_____
Localizada o Localizadas

Estas fotografias serán archivadas en mi historia clínica, manteniéndose en todo momento la confidencialidad de acuerdo con las normas de confidencialidad y procedimientos de la compañía. Solo serán deliverados a entidades señaladas, bajo el concentimiento de tratamiento previamente firmado por mi Este concentimiento es titulado: Autorización de Tratamientos, Asignación de Beneficios y Autorización para que el Gobierno Federal, bajo los programas de Medicare / Medicaid o cualquier otro programa similar como Hospitales, Seguros Médicos que paguen a All Around Home Health Agency, Inc. agencia de cuidados médicos a domicilio.

_____ _____
Firma del Paciente Fecha

_____ _____
Firma del Testigo Fecha

Alliance Home Health of Broward

Consent To Photograph

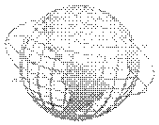
I, _____ a current client of ALLIANCE HOME HEALTH OF BROWARD, hereby designated person(s) to;

Take photographs of appropriate parts of my body in order to provide supporting documentation of my condition. I understand that any photographs taken will be placed in and remain part of my clinical record. It is understood that these records will be held in strictest confidence.

Client Signature: _____ Date: / /

Client Name: _____ Date: / /

Employee Signature: _____ Date: / /



CARELAND HOME HEALTH SERVICES

AUTHORIZATION AND CONSENT
PHOTOGRAPH AND PUBLICATION

The undersigned hereby authorizes Careland Home Health Services Co Agency to photograph or permit other persons to photograph _____ (patient's name) while under the care of the above-named Agency. The undersigned agrees that the above-named Agency may use and permit other persons to use the negatives or prints prepared from such photographs for such purposes and in such manner as may be deemed appropriate. The undersigned agrees the photographs may be used for purposes including, but not limited to, dissemination to Agency staff, physicians, health professionals and members of the public for educational, treatment, research, scientific, public relations and charitable purposes. This photography/filming is intended for the following circumstances:

_____

_____

_____

Dissemination of the photography/filming may be accomplished in any manner and that such use is subject only to the following limitations:

_____

_____

_____

The undersigned has entered into this agreement in order to assist scientific treatment, educational, public relations and charitable goals and hereby waives any right to compensations for such uses by reasons of the foregoing authorization, and the undersigned and his/her successors or assignees hereby hold the above-named Agency and the attending physician and their successors and assignees harmless from any or against any claim for injury or compensation resulting from the activities authorized by this agreement.

The term "photograph," as used in the foregoing agreement, shall mean motion picture or still photography in any format, as well as videotape, video disc, electronic, audio media and any other mechanical means of recording and reproducing images or voice.

Date: _____ Time: _____ AM/PM Signature: _____
Patient/Parent/Conservator/Guardian

_____ _____
Signature of Witness If signed by other than Patient, indicate relationship

Comfort Care Home Services, Corp.

CONSENT TO TAKE PHOTOGRAPHS

PATIENT NAME: _____ MR#: _____

I, _____ HEREBY GRANT PERMISSION TO **Comfort Care Home Services, Corp.** TO TAKE PHOTOGRAPHS OF

_____

(PT'S NAME) (AREA OF BODY)

I UNDERSTAND THAT THESE PHOTOGRAPHS IS DOCUMENTATION PURPOSES AS PER AGENCY POLICY, AS WELL AS FOR DECISION MAKING PURPOSES IN DEVELOPING MY PLAN OF TREATMENT. I FURTHER GRANT TO **Comfort Care Home Services, Corp.** THE AGREEMENT FOR

_____ _____

(PATIENT SIGNATURE) (DATE)

_____ _____

(PATIENT REPRESENTATIVE SIGNATURE) (DATE)

_____ _____

(WITNESS) (FECHA)

CONSENTIMIENTO PARA TOMAR FOTOGRAFIAS

NOMBRE DEL PACIENTE _____ MR#: _____

YO, _____ CONCEDO PERMISO A **Comfort Care Home Services, Corp.** PARA TOMAR FOTOGRAFIA.

DE _____ _____

(NOMBRE DEL PACIENTE) (AREA DEL CUERPO)

YO ENTIENDO QUE EL USO DE ESTAS FOTOGRAFIAS SON PARA LA DOCUMENTACION QUE REQUIERE LA POLIZA DE LA AGENCIA Y TAMBIEN PARA AYUDAR A FORMULAR MI PLAN DE TRATAMIENTO, ADEMAS YO CONCEDO A **Comfort Care Home Services, Corp.** EL CONVENIO DE SERVICIO AL CLIENTE

_____ _____

(FIRMA DEL PACIENTE) (FECHA)

_____ _____

(FIRMA DEL REPRESENTANTE DEL PACIENTE) (FECHA)

_____ _____

(TESTIGO) (FECHA)