Northwest Anesthesiology and Pain Services, PA

HOUSTON PAIN SPECIALISTS

# CONSENT FOR PHOTOGRAPHY, VIDEO/AUDIO RECORDINGS AND/OR TO TELEVISE PATIENTS

(Images taken for the purposes of treatment, payment and/or health care operations)

**Patient Name:** _____

**Last** **First** **M.I.**

**Date of Birth:** _____

I consent to have my image taken by the staff of Houston Pain Specialists , a provider for Northwest Anesthesiology & Pain Services, PA (NWAP), as described below:

I understand that my image, including photographs, digital images, video recordings, etc., will be recorded for the purpose of assisting in my care, documenting my treatment for payment reasons, and assisting in certain health care operations NWAP conducts including quality care initiatives.

For reasons other than treatment, payment, health care operations or education purposes as described above, I understand that NWAP will require me or my personal representative to sign a written authorization form in order to use or disclose my images.

I understand that NWAP will own these images, but I will be allowed to view them or obtain copies of them.

I certify this form has been fully explained to me. I have read it or have had it read to me, and I understand its contents. I agree to have my image taken by NWAP according to the conditions listed above.

_____ _____

Signature of the Patient or Personal Representative Date

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