

Angela Scheuerle, M.D., P.A.

Photography Release

Patient Name: _____ Today's Date: _____

I, _____ hereby give Angela Scheuerle, M.D., P.A. permission to take pictures of **me/my child** (circle one) for inclusion in my medical record. I understand that I may have copies of these photos as with any other portion of my medical record. Additionally, I give permission that these pictures may be used as follows:

- a) for educational purposes in lectures, demonstrations and training of other health care providers, public health entities and students;
- b) for presentation at professional meetings;
- c) for publication in professional journals, books, websites and other media with copyright in her name or a name otherwise chose.

I understand that my name, the name of y child or other family members and other specifically identifying information (address, phone number, medical record numbers, etc.) will be respected as confidential information as covered under the federal HIPAA Privacy Rule guidelines.

These permissions are absolute and irrevocable. I hereby release and discharge Angela Scheuerle, M.D., P.A. from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.

Patient/Legal Guardian Signature

Relationship to minor

Witness