Family Physicians of Richardson

2821 E. President George Bush Hwy.
Richardson, Texas 75082
P: 972.664.0404 F: 972.664.9797

I normally get my prescriptions from:

Pharmacy Name: _____ Pharmacy Phone: _____

Address: _____
STREET CITY STATE ZIP

I authorize this office to have access to my prescription drug history.

_____
PATIENT NAME PRINTED **DATE**

_____
PATIENT SIGNATURE

The remainder of this form is optional.

We are required to ask the following questions in order to meet Federal electronic medical records requirements.

PRIMARY LANGUAGE: _____

ETHNICITY: _____

(GENETIC BACKGROUND)

RACE: _____

(CULTURAL ASSOCIATION)

34. PHOTOGRAPHY POLICY FORM

CONSENT FOR MEDICAL PHOTOGRAPHY

Purpose: For medical records, consultation, teaching, and publication

I understand that photographs, videotaping, and other digital recordings may be made and recorded of me. I understand the term "medical images" as used here includes electronic as well as printed images. I understand and agree that the nature of use of these images is for purposes of medical records, consultation, teaching, and publication. Although measures will be taken to reduce or eliminate identifying features, the possibility remains that someone may recognize me.

The use of medical images for medical records includes recording and saving images in the print and or digital records for office use. The use of medical images for consultation purposes includes sharing of these images with other healthcare providers who are involved in the diagnosis and treatment of my conditions. The use of medical images for teaching purposes includes the use of my images for teaching medical students, medical residents, practicing physicians and other healthcare professionals. The use of medical images for publication includes my images or recordings in print or online medical journal publications. I understand that if I allow my images be used in publications, I have the right to revoke this consent up until the time the images are accepted for publication. Once the images have been published, I may not revoke my consent. Anonymity cannot be guaranteed in publications.

I have been provided the opportunity to ask questions concerning medical photography and understand that refusal to consent will not affect my medical care. If the patient is under 18 years of age, I verify that I am the parent or guardian of patient_____, and that I will sign for the patient.

_____ I consent to allow medical photographs for all purposes described above.
_____ I consent to allow medical photographs for only purposes that I have checked below.
_____ Medical records _____ Consultation
_____ Teaching purposes _____ Publication
_____ I do not provide consent to allow recording or saving of medical photographs.

Date_____ Time_____
Place: Family Physicians of Richardson
Signature of patient: _____ (Guardian/relative)
Witness: _____ (Office Personnel)
Signature: _____