Photographic Consent/HIPAA Authorization

I, ____ (Last Name, First Name), _______________
____________________________ (relationship to patient) hereby consent to Avila Integrative Medicine taking medical images and/or video being made or me/my child/my dependant/ the patient.

I agree that the de-identified images taken may be:

- Placed in my medical record for future reference and/or treatment
- Used by health professionals for teaching and training purposes
- Will not be used for advertising or packaging

I understand that Avila Integrative Medicine will make every attempt to remove any identifying information that would qualify as protected health information ('PHI") before authorizing the images for use. I understand that complete anonymity cannot be guaranteed.

I understand that I may revoke the Authorization at any time, except to the extent that Avila Integrative Medicine has taken action in reliance on it. My revocation will only be effective if I submit it in writing to Avila Integrative Medicine. I understand that I am not required to sign.

Authorized Signature:_____________________________________ Date:____________________

AIM Representative:______________________________________ Date:____________________