**Patient Acknowledgement of "No Video or Photo Allowed" Policy**

This form acknowledges that the patient understands and agrees to the policy regarding the prohibition of video and photography within the premises of Fayetteville Dermatology. This policy is in place to protect patient privacy and maintain a secure environment.

Policy Statement

Patients and visitors are not permitted to take photographs, videos, or audio recordings of any kind within the premises of Fayetteville Dermatology without prior written consent and supervision from an authorized staff member.

* This includes the use of cell phones, cameras, tablets, or any other recording devices.
* Staff members are not authorized to give permission for photography or recording within the facility and are authorized to enforce this policy.
* In instances where photography or recording is deemed necessary for patient care (e.g., documenting a wound), such recordings will be taken by authorized personnel using clinic-owned equipment and stored securely as part of the patient's medical record, [in accordance with established policies](https://www.accountablehq.com/post/hipaa-and-photography).

Purpose of the Policy

This policy is implemented to:

* **Protect Patient Privacy:** Ensure the confidentiality of patient information and prevent unauthorized disclosure of Protected Health Information (PHI).
* **Maintain Security:** Preserve a safe and secure environment for all patients, visitors, and staff.
* **Comply with Regulations:** Adhere to state and federal laws and regulations governing patient privacy and healthcare operations, such as HIPAA.

Patient Acknowledgement

By signing below, the patient acknowledges that they have read and understood the "No Video or Photo Allowed" policy of Fayetteville Dermatology. They agree to follow this policy during their visit. Violating this policy may result in a request to stop recording or to leave the premises.

Patient Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If copies of medical records are needed, including images or other documentation, contact the office to make a formal request and use the designated process for accessing the information.