**NEW YORK CITY**
**HEALTH AND HOSPITALS CORPORATION**

# Consent to Take and Access Photographs / Films

**I, ________________________, hereby consent to have photographs / films taken of**
**(Print patient's name)**

**myself by the staff at ____________________________ Hospital/Facility for the**
**(Name of Hospital/Facility)**

**purpose of documenting the injuries I sustained on _____________________.**
**(Date)**

**I have been informed of the Hospital's/Facility's policy and procedures with regard to maintaining evidence for victims of domestic violence which includes photographs and/or film.**

**I understand that the photographs will be identified by a number corresponding to my medical record but the photographs will not become a part of my medical record.**

**I understand that the photographs may be accessed for treatment purposes and follow-up activities by the medical staff and Domestic Violence Coordinators/Social Workers at the Hospital/Facility.**

**By initialing the box below, I hereby agree to allow my photographs to be accessed for treatment purposes and follow-up activities by the medical staff and Domestic Violence Coordinators/Social Workers at other Hospitals operated by the New York City Health and Hospitals Corporation.**

Initials [ ]

_____________________________ _____________________
**Signature of Patient** **Date**

______________________________/______ ___________________________/______
**Signature / Title of Health Care Provider Obtaining Consent** **Date** **Signature of Translator/if applicable** **Date**

HHC 2421 (Nov 03)