Optimum Internal Medicine & Pediatrics
Christopher S. Burress, DO | 10044 Hwy 46, Bon Aqua, TN 37025
Phone/Text 931-996-4247 | Fax 888-814-0893 | optimumimpeds.com

Procedure Video Authorization

Optional recording and educational use

Please read both pages, choose each permitted use, and ask questions before signing. This form covers recording and educational use only. It does not give consent for the medical procedure itself.

Patient name _____ Birth date _____

Procedure _____ Procedure date _____

Body area to be recorded _____

1 What I authorize

I authorize Optimum Internal Medicine & Pediatrics, Christopher S. Burress, DO, and the clinic's workforce to record only the procedure and treated body area described above, securely review and edit the recording, and use or disclose the resulting video clips or still images only for the educational purposes I select below.

The recording may show my condition, procedure, and treated body area. That area is still an image of me. No face, patient voice, name, identifying tattoo or mark, record, label, or computer screen may be included in released material. The clinic will limit what is captured and remove identifiers, identifying context, and metadata before any educational release. Inadvertently captured identifiers must remain restricted to the clinic and must not be released.

Even after these steps, unusual features or the circumstances of a case could allow someone to recognize me. Complete anonymity cannot be guaranteed. This form does not authorize outside camera crews or disclosure of identifiable footage to outside editors.

2 My choices for use and disclosure

Check every use you allow. An unchecked box means no permission for that use. If no box is checked, do not record. Only de-identified material may be used for the selected audiences.

☐ Internal education for clinic staff and supervised clinical learners

☐ Professional medical education for clinicians or students, including professional presentations and restricted educational materials

☐ Public education on the clinic website, optimumimpeds.com, accessible worldwide

☐ Public education through clinic-controlled social media or video accounts
Name each platform/account: _____

☐ Public educational talks or printed/digital educational materials
Describe audience/materials: _____

☐ Other educational channel or audience, specified before signing:
_____

These choices do not authorize research, paid advertising, sale or licensing of footage, sponsored promotion, or unrelated commercial use. Those uses require separate permission.

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My Rights and Signature

Patient name _____ Procedure date _____

3 Participation is voluntary

I may refuse or limit permission, ask that recording stop, or withdraw permission. My choice will not affect my treatment, payment, health plan enrollment, or eligibility for benefits. I may receive care without agreeing to recording. Consent for treatment must be obtained separately.

4 Withdrawal and limits after release

I may revoke this authorization in writing by delivering or mailing a request to: Privacy Contact, Optimum Internal Medicine & Pediatrics, 10044 Hwy 46, Bon Aqua, TN 37025. I can call 931-996-4247 for help. Revocation stops future recording, use, and disclosure under this authorization, except to the extent the clinic has already acted in reliance on it.

The clinic cannot retrieve copies already distributed or control downloads, screenshots, sharing, or reposting by others. Information disclosed to the public may be shared again and may no longer be protected by HIPAA. Withdrawal cannot erase uses or disclosures already made.

5 When this authorization expires

Complete one before signing. Permission ends on the date or event below unless revoked earlier. Expiration stops new uses and disclosures under this authorization; it cannot undo prior releases.

☐ Date (month/day/year): _____
☐ Specific event related to me or this educational purpose: _____
_____

6 Agreement and signature

I have read both pages, or they have been read to me. My questions have been answered. I understand the recording limits, selected audiences, privacy risks, and my right to refuse or revoke. I authorize only the uses checked on page 1. I will receive a copy of this signed form. I am not waiving legal rights by signing.

Patient or authorized representative signature _____

Printed name _____ Date _____

Time _____ ☐ AM ☐ PM

If representative, relationship to patient _____

Legal authority to sign for this patient _____

Patient assent, when appropriate (optional) _____ Date _____

Clinic documentation

Staff name _____ Signature _____

Date _____ Time _____ ☐ AM ☐ PM

☐ Choices and expiration completed ☐ Representative authority verified if applicable
☐ Signed before recording and sedation ☐ Signed copy given to patient/representative

Confidential form: retain in the patient record; never include this signed form in released media.