Ryan Family Practice 300 S. Rath Ave. Suite 202. Ludington MI 49431

Consent for use of multimedia recording

Name:_____ DOB: _____

I hereby authorize picturess, audio, or video recordings to be made of me (or of the above named individual if the individual is legally unable to give consent) by Ryan Family Practice, while I am being seen as a patient of Dr James Ryan. Your picture, audio or video recording will not be shared with any agency or individual without your permission.

I understand that the said pictures, audio or video recordings is intended for the following purposes: To increase the quality of your care as a patient of Dr Ryan. Video recording is rarely used and we will always ask for your permission again, this typically would be for strokes or some unusual movement disorder. Most of the time we will be taking your photograph for your chart or recording the audio of your visit, both of which we will give you access to and are stored with the rest of your medical records; labs, imaging, appointment notes etc.

If you have any questions please feel free to ask Dr Ryan at any point in time.

Signature of individual or other legally authorized person:

_____ Date:_____

Permission obtained by:

_____ Date:_____

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