SOUTH ALAMO MEDICAL GROUP

"Our mission is to provide exceptional health care services with compassion and promptness."

Letter of Consent for Photographing Patients

I, _____, authorize South Alamo Medical Group

to photograph _____.

I understand that this photograph is to be kept in the patients file and to be used for medical record clarification purpose only.

All photographs are kept confidential as are all medical records according to the Health Insurance Portability and Accountability Act (HIPAA).

Print Patient Name: _____

DOB: _____

Signature: _____

Date: _____

All mail must be sent to South Alamo Medical Group, PO Box 240490, San Antonio, TX 78224
Centralized Office Phone # 210-222-0333
Centralized Fax # 210-928-4837

Downtown	**Pediatrics**	**Southside**	**Southeast**	**Northwest**
740 South Alamo	7355 Barlite, Ste 201	7355 Barlite, Ste 301	4203 E. Southcross	9215 Westover Hills Blvd
210-222-0333	210-222-0333	210-222-0333	210-222-0333	210-222-0333
Fax 210-928-4837	Fax 210-928-4837	Fax 210-928-4837	Fax 210-928-4837	Fax 210-928-4837