



Azalea Trail Nursing and
Rehabilitation Center
P.O. Box 457
Grand Saline, TX 75140
Phone: (903) 962-4226
info@azaleatrailnursinghome.com
www.azaleatrailnursinghome.com

Resident Name

Facility Name

Consent for Use of Photographs, Audiovisual Recordings, Newsletters/Newsprint and Skin/Wound Documentation

(Initial) I, the above-named resident **grant my consent** giving permission to the facility to take photographs for the purpose of skin/wound care documentation and facility identification purposes only.

(Initial) I, the above-named resident **deny my consent** giving permission to the facility to take photographs for the purpose of skin/wound care documentation and facility identification purposes only.

(Initial) I, the above-named resident, **grant my consent** for the facility to use my name and any photographs or audio visual recordings of myself for display, publication, or broadcast with no form of compensation. The photographs or recordings may be taken of me by the facility, employees, or persons outside the corporation for use in the facility and/or in the public media and/or publications used by the facility or its subsidiary. I understand that I may rescind this authorization at any time, and that I am to be consulted with on each occasion.

(Initial) I, the above-named resident, **deny my consent** for the facility to use my name and any photographs or audio visual recordings of myself for display, publication, or broadcast with no form of compensation. The photographs or recordings may be taken of me by the facility, employees, or persons outside the corporation for use in the facility and/or in the public media and/or publications used by the facility or its subsidiary. I understand that I may rescind this authorization at any time, and that I am to be consulted with on each occasion.

Request to Open Personal Mail

I, the above-named resident, am aware that the administrator of the facility or designee can assist in the opening and/or reading of my personal mail. I am also aware that the administrator or designee can assist in opening financially related mail addressed to me, such as checks, medical bills or statements, Medicare and Medicaid correspondence.

(Initial) Opening of Personal and/or Financial Mail is requested not requested (circle one)

I acknowledge that I have received before or at the time of admission and have had orally explained to me the above information:

Resident Signature

Date

Family Member/Legal Representative

Date