Pediatric Neurology of Jacksonville

Video/Voice Recording Consent Form (For Safety Purposes)

Location: **Pediatric Neurology of Jacksonville**
2601 University Blvd. West
Jacksonville, FL 32207

1. Introduction

We are requesting your consent to video/voice record your child(ren) interactions in our lobby and triage room. This video recording is for the purpose of enhancing safety and security. The recordings will be used to review incidents and improve safety protocols.

2. Purpose of Recording

The video recording will be used to:

Safety and Security: To document events and incidents that may occur, potentially aiding in investigations and improving safety measures.

3. Storage and Retention

The video recordings will be stored securely and accessed only by authorized personnel. The recordings will be retained for a period of 30 days and will be destroyed or archived according to company policy.

4. Rights and Responsibilities

You have the right to review the video recording if it is relevant to an incident that involves you.

You are responsible for your own actions and conduct while being recorded.

5. Consent

By signing below, I acknowledge that I have read and understand the information provided in this consent form and voluntarily consent to being video recorded for the purpose of safety and security.

Patient's name:_____
Parent Signature/Guardian:_____

Date: _____