**Medical Photography Consent Form**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consent to all medical images and / or video being made of me or my child/dependent not limited to one date of service. I agree that duplicates may be made for the referring doctor.

**I agree that the images may be:** (Please check Yes or No below to show type of consent)

Used for identification purposes

Used by health professionals for education and training

Used in paper or electronic health publications

Used in commercial broadcast

Used in marketing materials

I further acknowledge that there were no promises of compensation for such use of medical photo(s) and or video taken by **CLINIC NAME** as consented above.

**By signing below, I confirm that I understand this consent form.**

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Patient’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Representative Relationship to Patient