(Physician's name)
(Institution address, phone number, email)

CONSENT FOR PHOTOGRAPHS

I (patient/parent), _____, do hereby give my permission for photographs to be taken of _____.

I understand that these photos:

_____
Initials

May be placed in my medical record for documentation of my illness or injuries.

_____
Initials

May be used for medical educational purposes, but if so used, my name or family's name is not to be used to identify the photographs.

I release my physician and all persons caring for me or dealing with my (or my child's) photographs from all liability resulting from the taking and authorized use of these photos.

_____
Signature (Patient/Parent)

_____
Date