

Photo Consent Form

\_\_\_\_\_ I consent to being photographed and/or videotaped before, during and after treatment. These images will become a permanent part of my medical record.

**I give my permission for these images to also be used for (please initial):**

 \_\_\_\_\_ educational purposes

 \_\_\_\_\_ scientific publications

 \_\_\_\_\_ demonstration to other prospective patients

 \_\_\_\_\_ practice website/internet/program Facebook page

 \_\_\_\_\_ none of the above/ I do not give my permission

**I give permission for use of photos of my (please initial):**

 \_\_\_\_\_ face

 \_\_\_\_\_ body

 \_\_\_\_\_ breasts

 \_\_\_\_\_ none of the above/ I do not give my permission

I grant Morehouse Healthcare and Morehouse School of Medicine to edit, use and/or disclose any such photographs or recordings for the purposes outlined above. I understand that I may withdraw my consent to the above listed at any time.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_