Patient Label

CONSENT TO PHOTOGRAPH

(In the event a photograph is taken, be sure to complete this form, including the patient's signature)

The undersigned hereby authorizes _____ and the attending
(NAME OF AGENCY)

clinician to photograph or permit other persons in the employ of this facility to photograph

_____ while under the care of this facility, and agrees
(NAME OF PATIENT)

that the negatives or prints be stored in patient's medical record, sealed in a separate envelope, in the event they may be needed later for evidence. These photographs will be released to the police or prosecutor only when the undersigned gives permission to release the medical records. The undersigned does not authorize any other use to be made of these photographs.

The photographs will be located in: _____
(LOCATION IN PATIENT'S CHART OR HEALTH FACILITY)

PATIENT'S SIGNATURE _____ DATE _____

WITNESS (PRINT NAME)_____ SIGNATURE _____ DATE _____

PROVIDER (PRINT NAME) _____ SIGNATURE _____ DATE _____

FOR MINOR PATIENTS: PARENT OR LEGAL GUARDIAN (PRINT NAME) _____

SIGNATURE _____ DATE _____

PATIENT'S STREET ADDRESS _____

CITY, STATE, ZIP _____

PHONE NUMBER _____