Patient Photo Consent Form

I hereby give consent for photograph(s) and/or video(s) of me or my child to be taken and used for the following purposes:

- Medical records
- Educational materials
- Clinic website and/or social media
- Other publications

Patient Name

Date of Birth

Parent/Guardian Name (if patient is under 18)

Limitations or exclusions for photos/videos (if any)

I understand that I may revoke consent at any time by submitting written notice to the clinic. This will not affect any actions taken before the withdrawal of consent.

Signature

Date