Patient Photo/Video Consent Form

This form seeks your consent to take, use, and share photos and/or videos of you for healthcare-related purposes.
Please read below and fill in your details.

Name of Patient

Date of Birth

Name of Parent/Guardian (if patient is under 18)

Contact Information

Consent Options

- [ ] I consent to photographs being taken
- [ ] I consent to videos being taken
- [ ] Use within healthcare provider's records
- [ ] Use for educational or promotional materials (e.g. website, brochures, publications)

Additional Comments or Restrictions

I understand that I may withdraw my consent at any time by contacting the healthcare provider in writing.

I confirm that I have read and understood this consent form.

Signature of Patient/Guardian

Date