Photo Consent Form

I authorize the staff of the healthcare facility to take photographs or video recordings of myself (or my child) in connection with the provision of healthcare services.

Patient Information

Patient Name

Date of Birth

Consent

- [ ] Consent for internal use (e.g. medical record, staff education)
- [ ] Consent for external use (e.g. publication, website, social media)

Restrictions or Special Instructions

Signature of Patient/Parent/Guardian

Date

If signed by parent/guardian, relationship to patient

Witness Name

Witness Signature

Date