Patient Photo/Video Consent

for Medical Facilities

Patient Name:

Date of Birth:

Medical Record Number:

I hereby consent to the use of photographs and/or video recordings of myself (or my child/dependent) taken at this medical facility, for purposes including but not limited to medical documentation, education, research, publications, and presentations.

☐ I give permission for my photo/video to be included in my medical record.

☐ I give permission for my photo/video to be used for educational and informational purposes (teaching, seminars, publications).

☐ I give permission for my photo/video to be used for facility marketing or promotional materials.

Any restrictions or comments:

_____

Patient/Guardian Signature

_____

Date

_____

Witness

_____

Date