Patient Photo/Video Consent for Medical Use

Patient Name

Date of Birth

Healthcare Provider/Facility

Description of Photo/Video (area, purpose, etc.)

Consent Options

☐ Use in my medical record ☐ Use for educational purposes ☐ Use in publications (journals, online, etc.)

☐ Other (specify below)

Limitations or Restrictions (if any)

Patient / Legal Representative Statement

I understand that my/my childâ€™s photo/video may be used as selected above. I understand that I may withdraw or restrict my consent at any time by notifying the facility in writing.

Signature

Date

Printed Name of Legal Representative (if applicable)

Relationship to Patient

Staff/Witness Signature

Date