Medical Patient Photo Release Consent Form

Patient Name

Date of Birth

I hereby grant permission to the healthcare provider and its representatives to take and use photographs, images or videos of me for the purposes of medical documentation, treatment, educational, or other healthcare-related purposes. I understand that my identity will be protected to the extent possible according to applicable laws and regulations.

Purpose(s) of Use (if applicable)

Limitations or Restrictions (if any)

Patient/Guardian Signature

Date

Printed Name

If patient is under 18 years of age, parent/guardian consent is required.