

Photo Consent Form

\_\_\_\_\_ I consent to being photographed and/or videotaped before, during and after treatment. These images will become a permanent part of my medical record.

**I give my permission for these images to also be used for (please initial):**

\_\_\_\_\_ educational purposes

\_\_\_\_\_ scientific publications

\_\_\_\_\_ demonstration to other prospective patients

\_\_\_\_\_ practice website/internet/program Facebook page

\_\_\_\_\_ none of the above/ I do not give my permission

**I give permission for use of photos of my (please initial):**

\_\_\_\_\_ face

\_\_\_\_\_ body

\_\_\_\_\_ breasts

\_\_\_\_\_ none of the above/ I do not give my permission

I grant Morehouse Healthcare and Morehouse School of Medicine to edit, use and/or disclose any such photographs or recordings for the purposes outlined above. I understand that I may withdraw my consent to the above listed at any time.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_