Morehouse Healthcare

DZIFA S. KPODZO M.D., MPH
PHOTO CONSENT

Please initial in spaces below to indicate your consent:

_____ 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
_____ other publications
_____ demonstration to other prospective patients
_____ practice website/internet/Website of Dzifa S. Kpodzo M.D., MPH
_____ Other _____

I give permission for use of photos of my:

_____ face
_____ body
_____ breasts

I grant Morehouse School of Medicine and Dr. Dzifa S. Kpodzo to edit, use and/or disclose any such photographs or recordings for the purposes outlined above. I waive the right to inspect or approve my depictions in these works. Unless I request in writing otherwise, I understand that this authorization will expire one-hundred (100) years from the day on which I signed this authorization.

Patient Name: _____ Date: _____

Patient Signature: _____

Witness Name: _____ Date: _____

Witness Signature: _____