

# CONSENT FOR PHOTOGRAPHS

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**DATE:** \_\_\_\_\_

**PATIENT'S NAME:** \_\_\_\_\_

**In connection with the medical services I am receiving from Dr. Christopher J. Saunders, I consent that photographs may be taken of me or parts of my body, under the following conditions:**

- 1. The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him.**
- 2. The photographs shall be taken by my physician or by a photographer approved by my physician.**
- 3. The photographs shall be used for medical records, and if in the judgment of my physician, medical research, education, or science will benefit by their use, such photographs and information relating to my case may be published and republished either separately or in connection with each other, in professional journals or medical books, or used for any other purposes which may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use, I shall not be identified by name.**
- 4. The above mentioned photographs may be modified or retouched in any way that my physician, in his direction, may consider desirable.**

**PATIENT SIGNATURE:** \_\_\_\_\_

**(Or if minor, Parents Signature above)**