PATIENT CONSENT FOR IDENTIFICATION PHOTOGRAPH

Patient name: _____ Date: _____

____ Check here if minor or unable to provide consent

I consent for a photograph to be made of me or my child (or person for whom I am a legal guardian). I understand that the information will only be used for identification purposes and will be stored securely. Refusal to photograph will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact: _____

By signing this consent form, I confirm that this consent form has been explained to me in terms that I understand.

I agree to use of my image for medical records ONLY.

Signature: _____

Witness: _____

For patients between the ages of 7 and 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to use of my image as outlined above.

Signature: _____

Witness: _____

I Decline to have Identification Photograph taken ☐