CORNERTSTONE PLASTIC SURGERY

BY FREDERICK A. COVILLE, MD

MEDICAL PHOTOGRAPHY CONSENT FORM

PATIENT CONSENT

I,_____

First Name *Last Name* *Date of Birth*

Consent to medical mages and/or video being made of me, my child, or my dependent. I agree that duplicates may be made for the referring doctor.

I agree that the images may be:

(Please tick below to show consent)

	Yes	**No**
… placed in my medical record for treatment	☐	☐
… electronically emailed to my treating health professional	☐	☐
… used by health professionals for education and training	☐	☐
… used in paper or electronic health publications	☐	☐
… used in commercial broadcast	☐	☐
… used in marketing materials	☐	☐

By signing below, I confirm that I understand this consent form.

_____

Print name:

_____

Signature of patient/parent/guardian: Date

_____

Signature of Doctor/Health Professional/Staff: Date