INDIGO DERMATOLOGY

Medical Photography Consent Form

PATIENT CONSENT

I, _____, _____
First name, Last Name **Date of Birth**

Consent to medical images and / or video images being made of me or (child, if the child is the patient) not limited to one date of service. I agree that duplicates may be made for the referring doctor.

I agree that my images may be:
(Please check yes or no to show type of consent)

	Yes	*No*
(___) **used by Health Professionals as part of Electronic Health Records**	____	____
(___) **used by Health Professionals for education and training**	____	____
(___) **used for "Before and After" purposes at the providers discretion**	____	____
(___) **used in marketing materials**	____	____

I further acknowledge that there were no promises of compensation for such use of my medical photo(s) and/ or video taken by Indigo Dermatology as consented above.

***** This consent may be revoked at any time by the "signing patient" with written consent.*****

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

_____ _____
Signature of Patient/ Parent or Guardian: Date:

_____ _____
Signature of Health Care Provider or Staff: Date