



# PATIENT CONSENT

## PHOTO + VIDEO

I, \_\_\_\_\_, DATE OF BIRTH \_\_\_\_\_  
FIRST NAME, LAST NAME DOB

CONSENT TO ALL MEDICAL IMAGES AND/OR VIDEO BEING MADE OF ME OR MY CHILD/DEPENDANT NOT LIMITED TO ONE DATE OF SERVICE. I AGREE THAT DUPLICATES MAY BE MADE FOR THE REFERRING DOCTOR.

- I AGREE THAT THE IMAGES MAY BE USED BY HEALTH PROFESSIONALS FOR EDUCATION AND TRAINING.
- I AGREE THAT THE IMAGES MAY BE USED IN PAPER OR ELECTRONIC HEALTH PUBLICATIONS.
- I AGREE THAT THE IMAGES MAY BE USED IN COMMERCIAL BROADCAST
- I AGREE THAT THE IMAGES MAY BE USED IN MARKETING MATERIALS

I FURTHER ACKNOWLEDGE THAT THERE WERE NO PROMISES OF COMPENSATION FOR SUCH USE OF THE MEDICAL PHOTO(S) AND OR VIDEO WAS TAKEN BY SHYLEE SKIN & WELLNESS AS CONSENTED ABOVE.

THIS CONSENT MAY BE REVOKED AT ANY TIME WITH A WRITTEN REQUEST BY THE PATIENT.

\_\_\_\_\_  
FIRST NAME, LAST NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE