The Anaplastology Clinic

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Consent to Photograph

Section A: *(only complete if the patient can provide their own consent, otherwise go to B)*

I, _____

(Print your name -- adult patient) **hereby grant permission to**

The Anaplastology Clinic to make photographic / video-taping / audio recording or illustrations of myself, the patient, which are deemed necessary for diagnostic purposes or to enhance the medical record. I further authorize the use of such illustrations for teaching purposes to illustrate scientific papers or lectures without inspection or approval on my part of the finished product or the specified use to which it may be applied.

Patient Signature: _____ **Date:** _____

Witness (print name): **Sign:** **Date:**

If Consent to Photograph is for a Minor:

Section B: *(for the patient who CANNOT provide their own consent)*

I /(we) hereby represent that we are the parent(s), guardian(s), and/or next-of-kin of

_____ **AGE:** _____

(Print name of minor)

I /(we) hereby grant permission to The Anaplastology Clinic to make:
photographic / video-taping / audio recording or illustrations of the minor (patient), which are deemed necessary for diagnostic purposes or to enhance the medical record. I /(we) further authorize the use of such illustrations for teaching purposes to illustrate scientific papers or lectures without inspection or approval on my part of the finished product or the specified use to which it may be applied.

Adult 1: (print name below)

_____ Signature 1: _____ **Date:** _____

Adult 2: (print name below)

_____ Signature 2: _____ **Date:** _____

Witness: (print name below)

_____ Signature: _____ **Date:** _____