Patient Consent for Medical Photography

Patient Name: ___________________________________ DOB: ______________

(Please print)

I, the undersigned, do hereby authorize *Siragusa Vein & Laser's* employees to take photographs or video of me while I am under their care.

I agree that they may use or permit other persons to use the electronic or print versions of my images for insurance purposes and to promote quality of care.

I agree that *Siragusa Vein and Laser* may utilize the pictures for publication in medical literature, for demonstration purposes online, and/or educational purposes, as well as in marketing material.

These photographs will be used without identifying information such as my name.

______________________________________ ______________________

Patient Signature Date