SKIN
DERMATOLOGY

CONSENT TO PHOTOGRAPH

I hereby consent to present a photo identification to confirm my identity as a patient who will receive treatment from Provider.

Photographs may be taken with a Practice owned camera for assessment and treatment of medical conditions. I understand that the photographic image will be stored in my confidential medical record.

Initial here if you are declining to have your photograph taken for treatment purposes ________.

I agree that I have read this form carefully and agree that everything in this agreement applies to current and future health care services provided by the Practice.

I also agree that I will inform all SKIN Dermatology, LLC physicians/providers and staff, at every visit, that I have declined to consent to any photographs.

______________________________	____________________	____________________
Patient Printed Name	Date	Patient Date of Birth
______________________________	____________________	
Patient Signature	Date	
______________________________	____________________	
Patient's Legal Guardian or Responsible Party (If Applicable)	Date	

SKIN Dermatology
1950 45th St. Suite 200 Munster, IN 46321
219-912-DERM (3376)
www.skinmedsurg.com