

CONSENT FOR PHOTOGRAPHS OR VIDEO

In connection with medical services I am receiving from Dr. Caster, I authorize photography or video imaging to be taken of me or clinically relevant parts of my body for medical records only, unless other uses are indicated below by my initials.*

Patient Printed name: ** _____

Patient Signature: ** _____

Patient's Agent/Representative's Signature: _____

Relationship to Patient: _____

Date: _____ Time: _____

*_____ By initialing here, I consent to use of my photographic or video images in a professional manner for publication, patient education, public seminar/display or promotional activities such as marketing, advertising, etc., including social media such as Facebook or similar outlets.