Photography Consent

I consent for medical photographs to be taken of me by the staff or representatives of Wolverine Dermatology. I understand that the images will be placed in my medical record and may be used for evaluation by employees of Wolverine Dermatology. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

I give permission for transfer of these photographs for continuing medical care (e.g. communication with my primary care physician).

Refusal to consent to photographs will in no way affect the medical care I will receive.

If I wish to withdraw my consent in the future, I may do so with a written request.

Patient: ____Date Of Birth:_________________________

Patient or Responsible Party Signature:_______________________________________ Date:__________________

Printed Name of Responsible Party:____ Capacity:_______________

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