Consent to Photograph

The undersigned hereby authorizes (name of agency) _____ and the attending provider to photograph or permit other people employed by this facility to photograph (name of patient) _____ while under the care of this facility and agrees that the negatives, prints or CD-ROM be stored in the patient's medical record, sealed in a separate envelope, in the event they may be needed later for evidence. These photographs will only be released to the police or prosecutor when the undersigned gives permission to release the medical records. The undersigned does not authorize any other use to be made of these photographs.

Date: _____

Patient's signature: _____

Witness: _____

Patient's parent/guardian of minor: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Adapted from: www.bcbsm.com/pdf/DV_ReferenceGuide.pdf