Print Form

MEDISYS
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MEDICAL PHOTOGRAPHY CONSENT FORM

Patient Consent

I, _____, consent to medical images and/or video being made of me or my child/dependent. I agree that duplicates may be made for the referring entity.

I agree that the images and results of my investigative tests may be placed in my medical record for future treatment, electronically emailed to my treating health professional, used by health
professionals for education and training, and/or used in paper or electronic health publications.

I release MediSys Rehabilitation, Inc. and those acting pursuant to its authority from liability for any violation of any personal or proprietary right I may have in connection with such use. I understand that all such recordings, in whatever medium, shall remain the property of MediSys Rehabilitation, Inc. By signing below, I confirm that I have read and fully understand this
consent form.

_____
Patient Name

_____ _____
Signature Date

_____ _____
Parent/Guardian Signature (if under 18) Date