# <u>Zeiter Eye Medical Group, Inc.</u>

# Medical Photography Consent Form

## PATIENT CONSENT

**I,_____, _____**
**First name, Last name** **DOB**

consent to all medical images and / or video being made of me or my child/dependant not limited to one date of service. I agree that duplicates may be made for the referring doctor.

**I agree that the images may be:**

(Please check Yes or No below to show type of consent)

| | **Yes** | **/ No** |
|---|---|---|
| … **used by health professionals for education and training** | ____ | ____ |
| … **used in paper or electronic health publications** | ____ | ____ |
| … **used in commercial broadcast** | ____ | ____ |
| … **used in marketing materials** | ____ | ____ |

I further acknowledge that there were no promises of compensation for such use of medical photo(s) and or video taken by Zeiter Eye Medical Group, Inc. as consented above.

This consent maybe revoked at any time with written request by patient.

**By signing below, I confirm that I understand this consent form.**

_____ _____
Signature of Patient/Parent or Guardian: Date:

_____ _____
Signature of Doctor/Health Professional/Staff: Date: