Gill Dermatology
DR. ANITA ARORA GILL

PHOTO CONSENT FORM

Patient Name: _____ Date: _____

I consent for medical photographs to be taken of me by Dr. Anita Arora Gill/Gill Dermatology or a representative. I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals. By consenting to these medical photographs I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. 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.

I authorize the use of these images: (Please initial indicating YES or NO below)

_____YES_____NO For demonstration purpose including an office photo album

_____YES_____NO On our website for prospective patients

_____YES_____NO In print advertisements and/or professional journals

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

_____ _____

Patient Name Printed/Date Patient Signature

_____ _____

Witness Name Printed/Date Witness Signature