Minor Photo Medical Release Form

Parent/Guardian Details

Full Name: _____

Relationship to Minor: _____

Address: _____

Phone Number: _____

Alternate Contact Number: _____

Minor's Details

Full Name: _____

Date of Birth: ____ / ____ / _____

Known Allergies or Medical Conditions:

_____

Primary Physician Name: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Purpose of Medical Photo Release

I authorize the medical staff at (Healthcare Facility/School/Organization Name) to photograph my child in the event of a medical emergency or for medical documentation purposes. These photographs may be used for:

☐ Medical Records Only

☐ Identification in Medical Emergencies

☐ Educational Purposes within the Medical Institution

Photographs will be kept confidential and used only as required for medical treatment.

Permission to Share with Third Parties

☐ I authorize the release of medical photographs to emergency responders if

Copyright @ SampleForms.com

necessary.

☐ I do NOT authorize any third-party sharing of these images.

Revocation and Expiration

This authorization is valid until ____ / ____ / _____. Written revocation of this consent is permitted at any time.

Parent/Guardian Signature

Signature: _____

Date: ____ / ____ / _____

Medical Representative Name: _____

Signature: _____

Date: ____ / ____ / _____

Copyright @ SampleForms.com