Aglow DERMATOLOGY Union Square

**853 Broadway @ 14TH Street**
**Suite 701**
**New York, New York 10003**
**T: 212-627-1004 | F: 212-473-2309**
**www.aglowdermatology.com**

# Medical Photography Consent Form

**PATIENT CONSENT**

**I,**

_____

*First name* *Last name* *dob*

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

**I agree that the images may be:**
(*Please tick below to show consent*)

| | **Yes** | **No** |
|---|---|---|
| … **placed in my medical record for future treatment** | _____ | _____ |
| … **electronically emailed to my treating health professional** | _____ | _____ |
| … **used by health professionals for education and training** | _____ | _____ |
| … **used in paper or electronic health publications** | _____ | _____ |
| … **used in commercial broadcast** | _____ | _____ |
| … **used in marketing materials** | _____ | _____ |

**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: