Kimberly Cockerham, MD
FACIAL AESTHETICS, LASERS & RECONSTRUCTIVE SURGERY
Zeiter Eye Medical Group, Inc.

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/dependent not limited to one date of service. I agree that dublicates 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