Patient Image and Video Capture Agreement

Patient Name:

Date of Birth:

Purpose of Capture:

Type(s) of Media (select all that apply):

- ☐ Photograph(s)
- ☐ Video(s)

Consent Agreement:

I consent to the capture and use of my images/videos by the clinic for the purposes described above. I understand that my identity and confidentiality will be protected as required by law.

- ☐ I agree

Patient Signature:

Date:

Submit