McLaren Ambulatory Care Center
McLaren/Bay Occupational Health/Convenient Care Center

CONSENT FOR PHOTOGRAPHY

This is to certify that I, the undersigned, give my consent to the center to take:

☐ Photographs ☐ Video ☐ Film ☐ Slides ☐ Audio
☐ Other _____

For the purpose of:

☐ Diagnosis, treatment recommendations and/or photographic documentation
☐ Identification while in treatment
☐ Other _____

I have the right to request cessation of recording or filming.

I understand the disposition of this media will be as follows:

☐ Retained as a permanent part of the medical record
☐ Destroyed upon discharge from treatment and not part of the permanent medical record
☐ Other _____

Furthermore, I understand some photography may be used for case studies, education and training of health care personnel. Personnel utilizing the photography will employ their best efforts to protect identity of the patient. Patient identifying information such as name, address, and medical record number will be obliterated.

I understand that I have the right to rescind consent for use up until a reasonable time before the recording or film is used.

I hereby waive any right that I may have to inspect or approve the finished product of this photography. In addition, I agree to release the center from any and all causes of action or liability resulting from the taking and use of such pictures.

Print Name: _____

Signature of Patient: _____ Date: _____ / _____ / _____

Witness: _____

If the patient is a minor or unable to consent, complete the following:

Patient (is a minor _____ years of age) is unable to consent because: _____

Legal Guardian or Closest Available Relative: _____

Print Name: _____

Signature: _____ Date: _____ / _____ / _____

Witness: _____

Physician's Signature: _____ Date: _____ / _____ / _____

Patient Name:

Date of Birth: